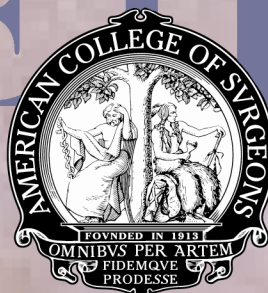


BULLETIN

AMERICAN COLLEGE OF SURGEONS



February 2002
Volume 87, Number 2



**Improving sight worldwide:
One surgeon's story**

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About the cover...

For the last 20 years, ORBIS, a not-for-profit organization based in New York, NY, has been flying ophthalmologists to developing lands to treat blind and nearly blind patients and to train surgeons and other health care professionals in the provision of advanced ophthalmic services. In "Surgeon takes flight to deliver improved sight worldwide," p. 12, Walter J. Kahn, MD, FACS, discusses his experiences as a volunteer for ORBIS.

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From my perspective

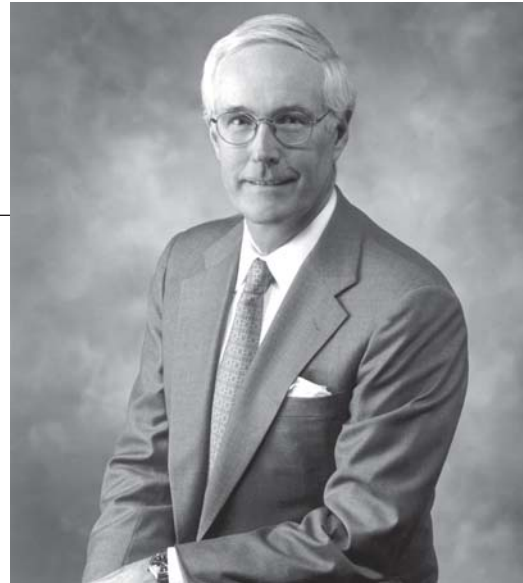
As the nation becomes more economically and emotionally stable after the events of last year, resolution of health care issues will once again occupy a prominent spot on the agendas of federal policymakers, medical organizations, and other stakeholders in the system. Topics that undoubtedly will be debated include health insurance reform, quality of care, and financial strains on surgeons and physicians.

Health insurance reform

The continuing controversies related to health insurance reform have, of course, been driven in large part by the ongoing escalation of health care costs. For example, it has been estimated that employers that provide medical benefits to their employees experienced an 11.2 percent increase in associated costs per worker last year. Employers anticipate that those expenses will go up another 13 percent in the year 2002. Further, the nation's health care expenditures now total more than \$1 trillion a year; and, according to recent government projections, health care spending in the U.S. will double over the next decade to \$2.6 trillion, with employers covering most of the expenses. Despite these alarming economic numbers, huge numbers of people in this country have no insurance whatsoever, partly because many small businesses cannot afford to provide health insurance benefits for their workers.

Other factors will undoubtedly fuel the health insurance reform debate in the future. I would point out the fact that one of the major health insurance companies, Aetna Inc., recently laid off one-sixth of its workforce due to languishing enrollment and expectations of losing more subscribers as it raises rates and eliminates unprofitable plans.

While most players certainly can agree on the principles of insurance system reform, it is very difficult to arrive at any sort of consensus as to how to take these ideas and convert them into real, concrete changes in the system. Indeed, what is a clear-cut, positive solution to one stakeholder becomes the *bête noir* of the next. For instance, most people and organizations agree that the health insurance system should be reformed to ensure medical coverage for all Americans, regardless of economic status. How to achieve that goal, however, is the source of endless debate. Do we establish a



“Resolution of health care issues will once again occupy a prominent spot on the agendas of federal policymakers, medical organizations, and other stakeholders in the system.”

single-payor system, expand and improve managed care organizations, or offer vouchers so that people can buy their own health insurance policies? Who will benefit most from implementation of any of these methods?

Presently, coalitions representing large purchasers of health care are gathering and developing novel suggestions on ways to improve their ability to offer health insurance coverage. These groups and the corporations they represent have been continually alarmed by the escalating costs and are attempting to come up with appropriate solutions to the issue. Some businesses, for instances, are offering their employees “defined contribution” benefit plans. Under this strategy, employers provide a set amount of money for each employee's health benefits, and the employee decides which type of plan to purchase using the allowance. Discussion of these and other proposals have been and will continue to be prevalent for the foreseeable future.

Quality issues

There will also be increasing pressure on all surgeons, health care practitioners, hospitals, and other providers to make certain that their interventions and actions are based on solid medical and surgical evidence. Some stakeholders, such as the Leapfrog Group, even call for differentiating among providers on the basis of some sort of an evaluation system, so that the purchasers of health care can make better choices about where to send patients for treatment. Other organizations are demanding better use of information systems and technology with the ultimate aim of someday having medical records that are completely electronic and hopefully decreasing medical errors so that patient safety can be improved. Additionally, there are growing expectations that federal agencies and health care organizations will establish guidelines for treating specific diseases and conditions, thereby enabling physicians and providers to establish best practices.

Finally, many stakeholders believe that health care consumers should become more engaged in enhancing the quality of their health care, not only in their day-to-day living habits, but also in the way they select their health plans and their providers. Engagement of the public in their own health care is certainly a laudable goal, but it is also perhaps the most difficult to realize.

Financial strains

Another problem that has become endemic to the U.S. health care system is the ever-heightening financial burdens that physicians and other providers are expected to bear.

For example, physicians are paying higher malpractice insurance premiums because jury awards have risen to an average of \$3.49 million each. These hefty awards are, in turn, driving some malpractice carriers out of business. This past December, St. Paul Companies, the nation's major medical liability carrier, announced that it would exit the medical malpractice field and would no longer offer new policies because of mounting losses from medical malpractice. Meanwhile, physicians, hospitals, and others are expected to shoulder the costs through higher premiums. And the increased costs of premiums, unfortunately, are too often passed on to employers and consumers, adding approxi-

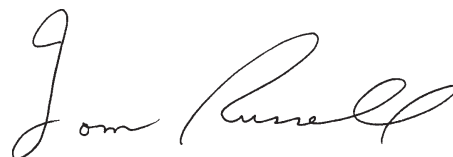
mately one percentage point to health care inflation.

In addition, reimbursement issues continue to plague the health care system. The Centers for Medicare & Medicaid Services (CMS) recently announced a delay in payment for hospital services and that the conversion factor that is used to calculate payments to physicians who provide Medicare services will decrease by 5.4 percent this year. This reduction brings payment per relative value unit down from \$38.26 to \$36.19 this year. As I noted in a previous column on this topic, the CMS cut the conversion factor because, under legislation that was enacted during the previous Administration, the annual conversion factor update is based on a "sustainable growth rate," which is tied to the business cycle rather than to health care costs (*Bulletin*, December 2001, p. 3). There clearly is a major flaw in the system under which CMS works and compensates providers.

These types of financial strains must be eased as part of any effort to reform the nation's health care system, so that the practice of surgery and medicine remains attractive to those surgeons and physicians who are committed to providing excellent care.

What we're doing

How these problems will be resolved remains to be seen. I can assure all of you that the American College of Surgeons will be closely monitoring all of these issues and will respond appropriately, either independently or as part of coalitions with other organizations. Clearly, surgeons and other health care practitioners have frequently been neglected in the national debates over health care reform. We will make certain that our members are appropriately represented as the controversies unfold and issues of concern to Fellows are discussed.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

❖ The **College's Health Policy Steering Committee** met in Washington, DC, on January 13 to discuss action on the Medicare payment update, the looming liability insurance crisis, and the need to assume a higher profile on the national bioterrorism readiness effort. The committee reviewed the College's continuing dialogues with private sector organizations such as the National Quality Forum and employer purchasers like the Leapfrog Group, as well as alliances that will support and advance the College's positions on socioeconomic and clinical issues. Other topics covered included support for state advocacy efforts to strengthen scope of practice, surgery's response to the nursing shortage, and determining the net impact of the direct medical education payment system by the Medicare Payment Advisory Committee.

❖ The American College of Surgeons will hold its **30th Annual Spring Meeting** April 14-17 at the Hyatt Regency San Diego. A major focus of the meeting, which is dedicated to addressing the interests and needs of the practicing general surgeon, will be the Assembly for General Surgeons, a "town-hall" session on "The Twenty-First Century Health Care System." Other highlights will include postgraduate courses on hands-on skills, coding, and informatics; the Excelsior Surgical Society/Edward D. Churchill Lecture; and several general panel presentations. The Program Planner for the Spring Meeting will be mailed this month. Online registration is available at <http://www.facs.org/2002springmeeting/index.html>. For further information, contact pblair@facs.org.

❖ John T. Preskitt, MD, FACS, and Frank G. Opelka, MD, FACS, recently represented the College at the first meeting of the **CPT Editorial Panel Evaluation and Management (E&M) Workgroup** of the American Medical Association. The workgroup will evaluate current levels of E&M codes to ensure that they clearly and effectively describe what physicians do (functionality) and improve physicians' ability to accurately use the codes in submitting claims (utility).

❖ The **American Society of Colon and Rectal Surgeons (ASCRS)** is making a Webcast of more than 30 hours of scientific material presented at its 2001 annual meeting available at no cost to visitors to its Web site. Simply log onto <http://www.fascrs.org> and access the link on the homepage to broaden your knowledge of diseases of the colon and rectum and use these online programs for your teaching activities.

❖ The **General Surgery Coding and Reimbursement Committee** met on January 11 to provide input regarding CPT codes, the activities of the American Medical Association/Specialty Society Relative Value Update Committee (RUC) and the Practice Expense Advisory Committee (PEAC), and problems regarding the Medicare fee schedule. They also provided detailed recommendations on practice management education for ACS Fellows. John O. Gage, MD, FACS, and Charles D. Mabry, MD, FACS, will be meeting with the RUC and PEAC as representatives of general surgery to ensure that reimbursement codes reflect both the work done and appropriate practice management costs.

Dateline|Washington

prepared by the Division of Advocacy and Health Policy

Congress fails to halt Medicare pay cut

Congress adjourned for the year on December 20 without taking action on S. 1707/H.R. 3351, the Medicare Physician Payment Fairness Act. This legislation, introduced by Sens. Jim Jeffords (I-VT) and John Breaux (D-LA), and by Reps. Michael Bilirakis (R-FL) and Sherrod Brown (D-OH), would have shaved 4.8 percentage points off the 5.4 percent across-the-board reduction in Medicare physician payments that took effect in January 2002.

Beginning January 1, the Medicare fee schedule conversion factor was set at approximately \$36.20, down from \$38.26 in 2001. The loss occurred despite a broad-reaching grassroots lobbying campaign involving the College's active participation, which generated support from majorities in both the Senate and House. The payment reduction occurred because of major flaws in the formula that is used to calculate Medicare physician payments.

Trauma funding increases in 2002

During the last days of its first session, the 107th Congress approved \$3.5 million in fiscal year (FY) 2002 funding for the Trauma Care Systems Planning and Development Act (Title XII of the Public Health Service Act), which provides federal grants to assist states in planning, developing, and coordinating statewide trauma systems. The trauma care program funding was included as part of a larger spending bill for the Departments of Health and Human Services, Labor, and Education.

For FY 2001, Congress had approved \$3 million for the trauma program, most of which has been used by the Health Resources and Services Administration (HRSA) to conduct a state-by-state needs assessment of trauma system capabilities around the country. Trauma funding advocates anticipate that the results of the study, expected shortly, will clearly illustrate the patchwork nature of the nation's trauma care network and bolster the argument for significantly increased program funding.

The College is taking initial steps toward persuading Congress to reauthorize the program for an additional four years. It also is working with Congress to address trauma care system needs as part of new efforts to improve the nation's preparedness to respond to acts of bioterrorism. H.R. 3448, the Public Health Security and Bioterrorism Response Act of 2001, recently passed by the House, includes a provision that would authorize increased funding to "develop and implement the trauma care component of the State plan for the provision of emergency medical services." A Senate-passed bioterrorism package does not include this provision. Legislators hope to resolve differences between the two bills as soon as possible.

Congress passes nursing shortage bills

On December 20, the Senate passed by unanimous consent a bill introduced earlier in the day by Sen. Barbara Mikulski (D-MD) that is intended to address the nation's current nursing shortage. The Nurse Reinvestment Act, S. 1864, combines two proposals passed by the Senate Health, Education, Labor, and Pensions Committee on November 1—S. 721, originally sponsored by Senator Mikulski and Sen. Tim

CMS says health care spending increased in 2002

Hutchinson (R-AR), and S. 1597, sponsored by Sens. John F. Kerry (D-MA) and James Jeffords (I-VT).

The Senate-passed legislation would create nursing scholarship programs to cover tuition, school expenses, and a \$400 monthly stipend for students who commit to serve at least two years in geographic areas with a critical shortage of nurses. It would also provide scholarships for graduate-level education in exchange for service teaching at an accredited school of nursing.

In addition, the Senate bill calls for creating a public awareness campaign to promote nursing as a career and for establishing a national commission to study and make recommendations on solutions to the nursing shortage. Grant programs would also be established to improve workplace conditions for nurses and create nurse retention and outreach programs. Finally, the measure calls for “career ladder” programs to encourage additional training and advancement within the profession.

The House introduced and passed similar but less sweeping legislation on December 20. Also titled the Nurse Reinvestment Act, H.R. 3487 was introduced by Rep. Michael Bilirakis (R-FL). Differences between the two bills will need to be resolved by a House-Senate conference committee.

According to a report issued by the Centers for Medicare & Medicaid Services (CMS) on January 8, health care spending in the U.S. rose to \$1.3 trillion in 2000, a 6.9 percent increase over the previous year. The increase for 2000 was notably higher than the 5.7 percent growth rate experienced in 1999 and was the highest annual increase recorded since 1993, when spending rose by 7.4 percent. CMS economists said the increase primarily reflected a rise in economy-wide inflation.

Health care spending averaged \$4,637 per person in 2000, compared to \$4,377 in 1999. Spending for prescription drugs once again led the pace of growth in 2000, although at a slower rate than recent years. Drug spending increased by 17.3 percent to a total of \$121.8 billion in 2000, compared with a 19.2 percent increase to a total of \$103.9 billion in 1999.

Spending for Medicare, the federal program for senior citizens and disabled individuals, was \$224 billion in 2000, an increase of 5.6 percent for the year. Medicare accounted for 38 percent of public spending on health care and 17 percent of overall health spending. Increases in Medicare spending were attributed largely to changes in provider payments, including those enacted in the Balanced Budget Refinement Act of 1999.

Federal and state spending for Medicaid totaled nearly \$202 billion in 2000, an increase of 8.3 percent from 1999. Federal and state spending for the State Children’s Health Insurance Program was \$2.8 billion in 2000, a 55 percent increase from the 1999 level.

The growth in expenditures in 1999 and 2000 slightly outpaced growth in gross domestic product. The share of GDP spent on health care increased from 13.1 percent in 1999 to 13.2 percent in 2000.

What surgeons should know about ...

OSHA regulation of blood-borne pathogens

by Adrienne Roberts, Government Affairs Associate, Division of Advocacy and Health Policy

As mandated by the Needlestick Safety and Prevention Act signed into law in 2000, changes were made to the Occupational Safety and Health Administration's (OSHA's) blood-borne pathogens standard. These changes, which became effective April 18, 2001, are intended to further protect health care workers and others in the medical community from exposure to blood-borne diseases, such as HIV and hepatitis, by imposing additional employee protection requirements on hospitals and private physician offices. The following questions and answers highlight some of the key requirements in the regulations from the surgeon's perspective.

Q. When was the blood-borne pathogens standard first issued?

A. The standard was released on December 6, 1991, based on OSHA's conclusion that employees face a significant health risk as a result of occupational exposure to blood and other potentially infectious materials. The original standard became effective on March 6, 1992.

Q. Who is covered by OSHA's blood-borne pathogens standard?

A. The standard applies to any person who may be exposed to blood or to other potentially infectious material containing blood-borne pathogens in the workplace. In the standard, OSHA defines occupational exposure as any "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other

potentially infectious materials that may result from the performance of the employee's duties."

Q. How did the Needlestick Safety and Prevention Act affect the OSHA blood-borne pathogens standard?

A. The law revised the blood-borne pathogens standard to incorporate a broader range of engineering controls, encourage improved documentation, and provide greater employee involvement in developing workplace controls. More specifically, the law directed OSHA to:

1. Include new examples in the definition of engineering controls.
2. Require that exposure control plans reflect changes in technology that eliminate or reduce exposure to blood-borne pathogens.
3. Require employers to document annually in the exposure control plans consideration and implementation of safer medical devices.
4. Require that employers solicit input from nonmanagerial employees responsible for direct patient care in the identification, evaluation, and selection of engineering and work practice controls.
5. Document this input in the exposure control plan.
6. Require employers to establish and maintain a log of percutaneous injuries from contaminated sharps.

Q. How do the current and previous definitions of engineering controls differ?

A. The new definition includes more examples of engineering controls. Previously, they were defined as “controls (for example, sharps disposal containers, self-sheathing needles) that isolate or remove the blood-borne pathogens hazard from the workplace.” The revised standard definition of engineering controls is much broader and includes “sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needleless systems.”

Q. What must employers do to comply with the new exposure control plan regulations?

A. The new standard mandates that employers “document annually in the exposure control plans consideration and implementation of safer medical devices” and consult with “non-managerial employees responsible for direct patient care in the identification, evaluation, and selection of engineering and work practice controls.” In an effort to include everyone in the health care community (physicians, nurses, assistants, and so forth) who is responsible for patient care, employers must consult with all personnel about the consideration and implementation of potentially safer instruments. This consultation must be included in the exposure control plan.

Q. What are employers required to do to comply with the new sharps injury log requirements?

A. The new record-keeping rule, effective January 1, 2002, requires employers to log all percutaneous injuries and any related illnesses involving exposure to blood and other potentially infectious materials (OPIM). Work-related needlesticks and cuts from sharp objects that are contaminated with another person’s blood or OPIM must be recorded in the log as an injury; however, for privacy reasons, the employee’s name should be omitted. If the employee is later diagnosed with an infectious blood-borne disease, the identity of the disease must be entered and the classification must be changed to an illness. If an employee is splashed or exposed to blood or OPIM without being cut or punctured, the incident must be recorded in the log only if the exposure results in the diagnosis of a blood-borne illness.

Q. Have studies been conducted to examine the potential costs of these changes?

A. The GAO released a study last November entitled *Occupational Safety: Selected Cost and Benefit Implications of Needlestick Prevention Devices for Hospitals* (#GAO-01-60R). It reports that “analysis of available data on the costs and preventability of needlestick injuries shows that the adoption of needles with safety features may be justifiable based solely on decreased initial treatment costs.” Also noted, “Needles with safety features may also reduce liability and worker’s compensation costs to hospitals when health care work-

ers acquire diseases after a needlestick injury.” For a copy of the response, please visit <http://www.gao.gov>.

Q. What about physicians who have established an independent practice, as opposed to those employed at a hospital? What is the difference between physicians as employers versus as employees?

A. In applying the provisions of the standard in situations involving physicians, the status of the physician is important. Physicians may be employers or employees. Physicians who are unincorporated sole proprietors or members of a bona fide partnership are employers and may be cited for violations of the standards if they employ at least one individual (such as a technician or secretary). Such physician-employers may be cited if they create or control blood-borne pathogens hazards that expose their employees at hospitals or other sites where they have staff privileges in accordance with the multi-employers worksite guidelines of compliance directive CPL 2-0.124, *Multi-Employer Citation Policy*.

However, because physicians in these situations are not themselves employees, citations may not be based on their exposure to the hazards of blood-borne diseases. In other words, depending on the circumstances, surgeons who employ a nurse to assist in procedures at a hospital at which they have privileges could be cited for actions that directly result in a nurse’s exposure to a blood-borne pathogens. On the other hand, depending on the circumstances, such a hospital cannot be cited for the surgeon’s exposure, if he or she is directly at fault.

Physicians may be employed by a hospital or another health care facility or may be members of a professional corporation that provides their services to a hospital and conduct some of their activities at hospital sites where they have staff

privileges. In general, professional corporations are the employers of their physician-members and must comply with the following standard provisions: hepatitis B vaccination, postexposure evaluation and follow-up, record keeping, and generic training provisions with respect to these physicians when they work at host employer sites. The hospital where these physician-members have staff privileges is not responsible for the above provisions but, in appropriate circumstances (for instance, not having a sharps bucket in an operating room), may be cited under other provisions of the standard in accordance with the multi-employer worksite guidelines of CPL 2-0.124.

Q. A number of states already have needlestick laws on the books; do these new requirements affect those laws?

A. OSHA’s revised blood-borne pathogens standard has raised questions about the status of those state laws. It has been established that the standard does preempt state laws “relating to issues in the private sector on which federal OSHA has promulgated occupational safety and health standards, such as the blood-borne pathogens standard, regardless of whether the requirements are more or less stringent.” Preemption is a complex legal matter that can only be finally resolved by the courts when raised by an affected party. OSHA does not take any formal legal or other action with regard to preemption of state activities. However, in general, the following principles apply:

1. *States with plans.* All OSHA-approved state plans are required to incorporate “at least as effective” needlestick protection for private sector and public sector (state and local government) employment, either through a standard or a state needlestick prevention law administered under the plan. To avoid the preemptive effect, state

needlestick prevention laws applicable to the private sector must be administered under the state plan.

2. *States without plans.* State needlestick laws and/or regulations in these states would not be affected by the preemptive effect of the federal blood-borne pathogens standard to the extent that they regulate the occupational safety and health conditions of public sector (state and local government) employment. However, state laws or programs that regulate private sector activities addressed by the federal blood-borne pathogens standard, absent an OSHA-approved state plan, would be subject to challenge as preempted.

Q. Where can a copy of the updated blood-borne pathogens standard and the accompanying compliance directive be obtained?

A. For a copy of the standard, go to http://www.osha-slc.gov/OshStd_data/1910_1030.html. The compliance directive, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens* (# CPL 2-2.69) establish policies and provides clarification to ensure uniform inspection procedures are followed when conducting inspections to enforce the blood-borne pathogens standard. Reviewing this document is the best way to determine if you are complying with the standard's requirements. It can be found on the Internet at http://www.osha-slc.gov/OshDoc/Directive_data/CPL_2-2_69.html.

Q. How can I get more information about compliance?

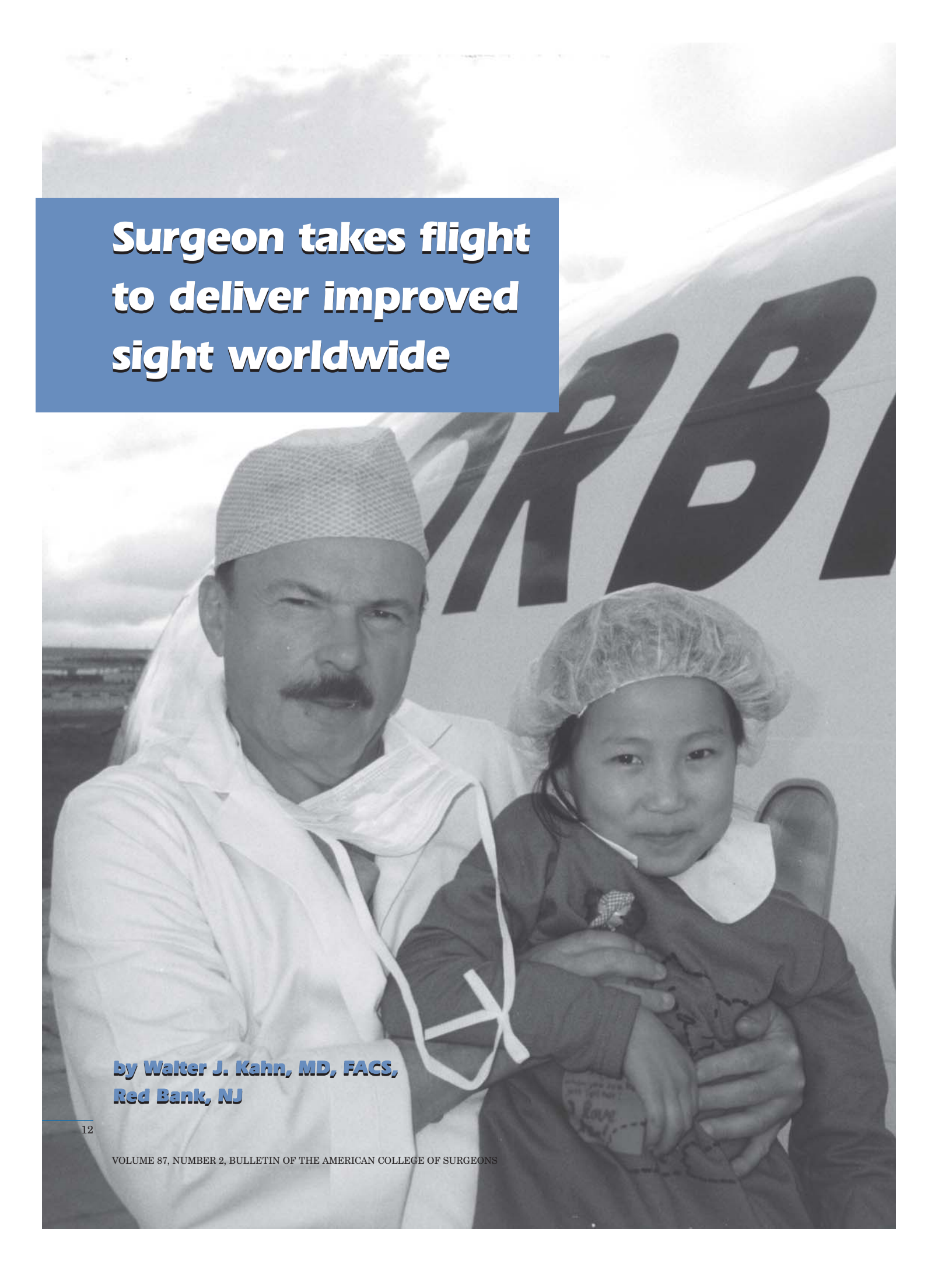
A. More information can be obtained by contacting OSHA on the Internet at <http://www.osha.gov>. 

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Occupational Safety and Health Administration: *Occupational Exposure to Bloodborne Pathogens Standard*, #1910.1030. Web site: http://www.osha-slc.gov/OshStd_data/1910_1030.html.



Surgeon takes flight to deliver improved sight worldwide

**by Walter J. Kahn, MD, FACS,
Red Bank, NJ**

I am in the back of a DC-10 in the Central Asian city of Tashkent, Uzbekistan. The weather is good, but the flight crew is missing, and I am very concerned. We are not in the air, and the plane is securely parked, so my cause for worry is not travel-related. Rather, I am thinking about the safety of a patient and whether the students aboard the plane understand what is happening. I am suturing a new cornea in place, and the procedure is being televised to the front of the plane, a 48-seat classroom. Questions abound from the observers and from my assistant, a local ophthalmologist.

This description is typical of the experiences I have had during the course of my 17 years of volunteering for an organization known as ORBIS.

What is ORBIS?

ORBIS is a not-for-profit humanitarian organization dedicated to saving sight worldwide through health education and hands-on training for ophthalmologists, nurses, and allied health practitioners.

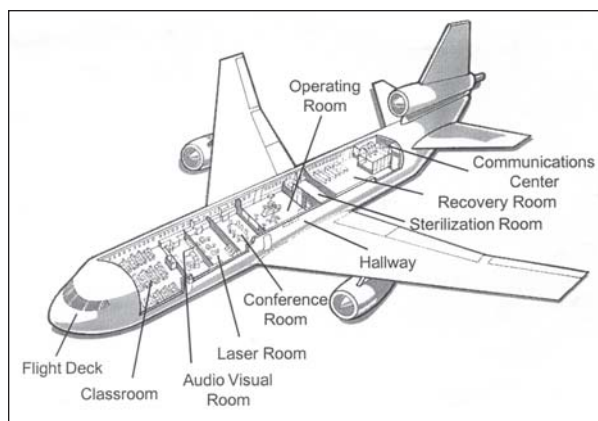
David Paton, MD, FACS, a Houston ophthalmologist, conceived the idea of an airborne ophthalmological teaching hospital in the mid-1970s. He wanted to bring American skills and expertise in ophthalmology to help personnel in developing countries. Dr. Paton's father was R. Townley Paton, MD, a prominent ophthalmologist and founder, in 1944, of the world's first eye bank, in New York, NY.

ORBIS was founded in 1982 with a grant from USAID and a DC-8, donated by United Airlines (the plane was extensively modified, and is now on display at the China Museum of Aerospace in Beijing). Since then, ORBIS has carried out more than 440 programs, both on and off the plane, in 80 countries and has trained more than 50,000 ophthalmologists, nurses, biomedical engineers, and related health care workers who, in turn, provide treatment and training in underserved countries. ORBIS is headquartered in New York, NY, and has international affiliates in Canada, Hong Kong, England, and France.

The ORBIS teaching facility is currently a DC-10 that was purchased for ORBIS in the early 1990s



The ORBIS aircraft in flight.



Floor-plan of the ORBIS DC-10 aircraft.

by A.L. Ueltschi (who founded Flight Safety International and who started his career as the personal pilot of Pan Am founder Juan Trippe), Y.C. Ho (a Hong Kong businessman), and an anonymous donor. The DC-10 houses a state-of-the-art operating room staffed by trained nurses and anesthesiologists, and also contains a fully staffed recovery room, laser facility, conference room, audio-visual equipment, satellite communications center, surgical instrument room, and a sterilization facility with its own water-purification system.

The work that ORBIS does is very important. Blindness is a problem of unreasonable proportions: more than 180 million people in the world are blind, severely visually impaired, or otherwise

Opposite page: The author, Dr. Kahn, with a patient in front of the ORBIS aircraft.



Dr. Kahn teaching in the DC-10 classroom.



Peripheral wet lab classroom in the DC-10.

at risk of losing their sight. The real tragedy of blindness is that about 80 percent of the people who are blind could be cured if they had access to the preventive and surgical techniques routinely practiced in the U.S. and other developed countries.

The heart of ORBIS is the DC-10 “flying eye hospital.” The aircraft spends 90 percent of its time in developing countries, home to most of the world’s blind people. These countries generally lack education in eye care and supplies, and suffer from restrictive government policies and cultural attitudes inhibiting the use of eye banks.

Each mission carried out by ORBIS is tailored to a particular region by an advance team, which coordinates with the host country months before we arrive. A follow-up team monitors the status of the patients after we leave.

My experience

I became involved with ORBIS in 1984, and my first mission was to Ouagadougou, Burkina Faso, in West Africa. Since then, I have participated in 10 missions in countries that include the Philippines, Haiti, India, China, Mongolia, Latvia, and

most recently (18 months ago) Uzbekistan. I enjoy taking a break in my practice, having the opportunity to contribute to the world’s health, and getting to see parts of the world I normally would never visit.

On these excursions, I typically have been part of a two-to-three-person group of visiting faculty, my specialty being cornea and cataract surgery. Other subspecialists represented in ORBIS include retina, glaucoma, pediatric, and oculoplastic surgeons. Each of us spends one intense week per year demonstrating surgery and giving lectures on ophthalmic procedures.

Our first day is spent at the host hospital, screening patients for surgery. Even though the patients are “prescreened” by the host physicians, the line of people waiting for treatment may wind around the block in 120-degree heat, each person desiring to be treated in that big plane from the sky. The pressure during the selection process can be very emotional. Some patients wear their World War II medals or cite other significant facts about themselves in hopes of gaining favor. One patient I treated in Uzbekistan was a retired general and



The DC-10 operating room.



The DC-10 recovery room.

another was an ophthalmologist. We select the five or six cases per day with teaching potential as the top priority and need as secondary. Then, the anesthesiologist evaluates the surgical risk for the selected cases.

The 25-member medical team is truly international, with representatives from the U.S., Canada, the Philippines, Great Britain, Ireland, India, Pakistan, Bulgaria, China, Iraq, and other parts of the world. The visiting surgical faculty are also international but predominantly American. The flight crew generally is composed of retired volunteers, who fly the plane every three weeks, then depart for home.

Everything is well coordinated by the front team—the one based in the country that we are visiting. The coordinating team determines the needs and wants of the host country, such as whether local health care practitioners are most interested in learning about corneal transplants or retina repair. Each country presents its own special challenges. Some illnesses are prevalent in certain countries but have been virtually eliminated from the rest of the world. Onchocerciasis

(river blindness), for instance, is a scourge in West Africa. Other countries pose unique situations for those of us from the West because of their cultural and religious views. Uzbekistan is a former Soviet republic that received its independence in 1991. The population is 60 to 70 percent Muslim but not very religious. Nonetheless, Muslim faith prohibits eye banks, so on this trip, we had to bring donor corneas from the U.S.

Each mission is truly fascinating, because we get right in the middle of the action as soon as we arrive. The ORBIS DC-10 is parked on a ramp area in the airport where it is accessible to the surgeons and their patients. (The plane uses its auxiliary power unit to provide needed electrical energy and air conditioning.) Generally, we are met by a crew member who escorts us to our hotel, where we participate in an orientation conference during which we discuss the local needs and the strengths and weaknesses of the area.

The program starts in the following morning. We leave the hotel, usually with a police escort, promptly at 7:00 am and start the operations at 8:00 am, continuing nonstop until about 6:00 pm.



In the first day of post-op in Uzbekistan: The patient was blind in both eyes due to opaque corneas and cataracts. A “triple procedure” (combined corneal transplant, cataract extraction, and lens implant) was performed on one eye. This was the first time she had been able to see in years, and she is so happy that she is crying.

All procedures are performed in slow motion with lots of interaction by the assistants and video audience. There are more than 20 video screens throughout the plane. At times, we also demonstrate at the local hospital to make the surgeons comfortable in their own setting with their equipment. In addition each of us gives 10-12 lectures during the week.

On most missions we train a few hundred ophthalmologists. They and the patients continually express their gratitude in countless ways. We are well received by the host doctors and government officials.

I have found the most difficult part is doing intricate surgery that is videotaped live while fighting jet lag. Jet lag is a problem because you are on a predetermined schedule with no time for a catnap. By the end of the week, we are really physically and emotionally washed out.

Memorable experiences

The 10 trips that I have taken through ORBIS have supplied me with indelible memories. I have met a number of prominent figures, including Mother Teresa, on our trip to Calcutta, India. Usually the president of the country or a designee will visit the plane. Shortly after we returned home after our work in Burkina Faso, we learned that the president, who had paid us a visit, was assassinated. No wonder there was an 11:00 pm curfew with shots fired at 11:01!

My wife, Susan, has accompanied me on several missions and has kept herself well-occupied handing out candy and magnifying glasses to the children and taking photos. We usually spend a few days after the work week seeing some of the sights, which are always fascinating. In Uzbekistan, the chair of my four-hospital-system board, an attorney, came along and enjoyed seeing a different side of medicine. He did help when we almost got arrested in the subway in Tashkent; the police thought we were taking pictures, which is forbidden there because the subway serves as a defense shelter for the city. They are very worried about Muslim fundamentalists.

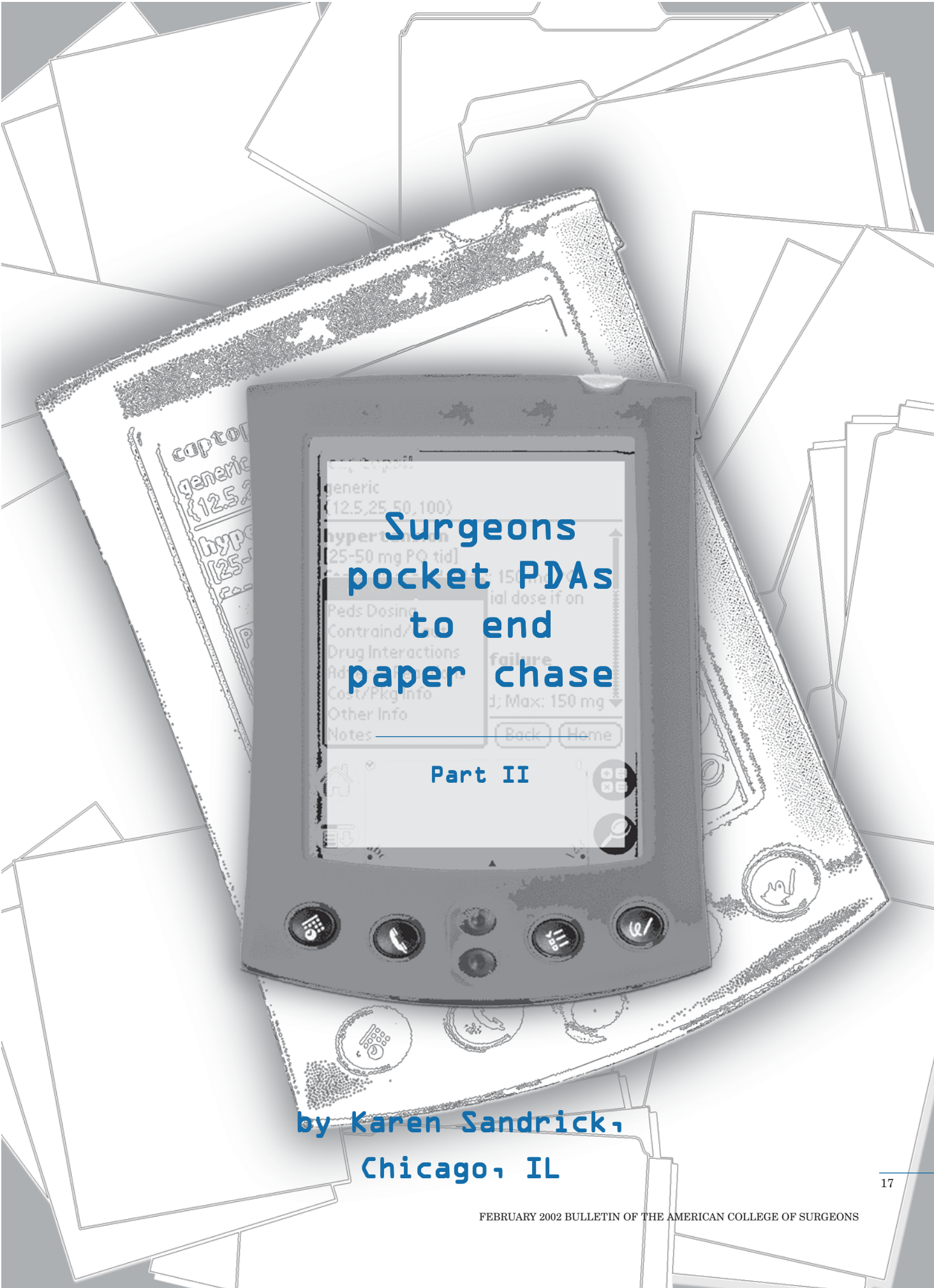
Nonetheless, Uzbekistan is a captivating country. It was part of the old silk route and encompasses the beautiful, historic Muslim cities of Bukhara and Samarkand, the latter of which is being restored. Tamerlane is the local hero to this day. In Tashkent, statues of Lenin have all been replaced with statues of Tamerlane.

Meanwhile, the people of Mongolia continue to idolize Genghis Khan. In the city Ulan Bator, one drinks Genghis Khan beer or Genghis Khan vodka while staying at the Genghis Khan Hotel.

Why do I look forward to these missions? Well, they give me a chance to do some good and offer a sense of adventure. And, it's a relief to practice medicine using U.S. standards but without worry about government restrictions, payment policies, CPT codes, and the threat of litigation. My involvement with ORBIS makes me feel appreciated, and I get to be a real doctor again.

For more information about ORBIS, visit the organization's Web site at www.orbis.org. 

Dr. Kahn is in private ophthalmic practice in Red Bank, NJ, and is a private pilot.



Surgeons pocket PDAs to end paper chase

Part II

by Karen Sandrick,
Chicago, IL

Neurosurgeon David W. Lowry, MD, FACS, started using a personal data assistant (PDA) when he was a surgical resident in 1997 just because he was tired of trying to fit an unwieldy daily planner into the pocket of his lab coat. Now in a busy neurosurgical practice in Grand Rapids, MI, he's turning to the device not only to keep his calendar and address book but also to generate postoperative notes and orders at the bedside and to organize information about surgical cases. A huge utility, he says, is the ability to tap into up-to-date drug treatment data with an electronic prescription drug reference program. "It's better than having a drug reference book in private practice," he said.

Like standard drug prescribing texts, the qRx™ program from ePocrates, Inc., San Carlos, CA, lists all medications that have been approved by the U.S. Food and Drug Administration. But rather than having to wait until the next edition of the *Physician's Desk Reference (PDR)* comes out, Dr. Lowry receives regular updates about the latest additions to the lists of available medications. Instead of having to thumb through page after page of the *PDR*, Dr. Lowry can get the details about a specific drug—whether he needs the pediatric or adult dosing schedule, mechanisms of action, or side effects—in a matter of seconds. He also can check on known drug interactions for up to 30 different medications—an invaluable option for surgical specialists who see patients with concomitant chronic diseases, he says. "If you have a patient coming in the office who's already taking 10 drugs and you're going to be adding another, you can give the patient and the referring physician a bit of a heads up about the potential problems that may occur," he said.

In the not-too-distant future, Dr. Lowry expects his PDA to be linked with surgical handbooks and online journals, clinical practice algorithms and guidelines, prescription pads, and other patient care applications. "I can very easily envision having a commonly used handbook on a hand-held computer, so I'll have information available to me whether I'm in the office or the hospital or somewhere else. I can see an infrared port at a nurses' station that surgeons can interact with to transmit medication orders directly to the pharmacy," he said.

"Companies are already working on applications for handling clinical utilities through hand-helds right at the point-of-care, where individual patient care decisions are made," Dr. Lowry notes.

Not just a notebook

Hand-held personal computers are ready-made vehicles for point-of-care record-keeping. PDAs also serve as convenient calculators, with programs that analyze arterial blood gas values; compute intravenous doses of medications for treating myocardial infarction, arrhythmia, and strokes; diagram the extent of burn wounds and determine the corresponding fluid requirements for a patient; and perform statistical exercises such as the chi square, Student and Fischer test, and so on.

PDAs are not merely handy notebooks or scratchpads, however. The devices organize information into databases, so quick memos about a patient, including name, date and type of surgery, and diagnosis, transform into a data source that can be searched by patient or by surgical problem. PDAs also can coalesce individual items of information about the type, nature, and location of a disease or condition, the characteristics of the patients who suffer from it, and the treatment options for addressing it and their success rates, so they can be analyzed to identify trends and begin documenting outcomes.

Also, as vehicles for evidence-based medicine, PDAs have great potential for eliminating errors, reducing variation in surgical practice, and improving patient care.

Currently, surgeons have access to software for hand-held computers that brings clinical textbooks, journal abstracts, dictionaries, meeting abstracts, and practice guidelines to their fingertips.

One company creating such software is Eureka.com, a division of the biological sciences book publisher Landes Bioscience, Georgetown, TX. Eureka.com is working with the department of surgery at Northwestern University School of Medicine, Chicago, IL, to provide an electronic handbook of surgical procedures complete with line anatomical drawings and lists of indications, operative principles, preoperative and postoperative considerations,

and possible complications. Eureka.com software also will allow surgeons to superimpose on standard anatomical drawings depictions of their approaches to surgical procedures and to download searchable databases of algorithms for assessing symptoms, managing diseases, and meeting best practice standards of care developed by subspecialists in major academic medical centers.

JournalToGo from HealthTech Solutions, St. Louis, MO, automatically delivers selected journal abstracts and other medical news to PDAs whenever they are hot synched with a surgeon's main computer system. *Taber's Cyclopedic Medical Dictionary* from F.A. Davis, Philadelphia, PA, has 56,000 online definitions that can be retrieved with the touch of a stylus on the face of a PDA.

Electronic abstracts from medical conferences are being provided by organizations such as the Congress of Neurological Surgeons, and downloadable clinical practice guidelines and algorithms are available from professional societies, expert panels, and other sources, such as the Advanced Cardiac Life Support (ACLS) algorithms, which display treatment alternatives for monomorphic and polymorphic ventricular tachycardia and other cardiac emergencies instantaneously on PDA screens.

"One side of hand-held computing people find indispensable to patient care is applications that bring medical knowledge base to the bedside," said David Krusch, MD, FACS, Chair of the College's Committee on Informatics and director of the University of Rochester Medical Center's Informatics Division in Rochester, MN. "You've taken your reference material out of the library, to the computer workstation, and have finally put it in your pocket."¹

Photographic databases

Some surgeons are creating their own PDA utilities. Sidney F. Miller, MD, FACS, professor of surgery at Wright State University and director of the Miami Valley Hospital Regional Adult Burn Center, Dayton, OH, attaches a digital camera to his PDA to record, at least on a weekly basis, the appearance of burn wounds.

Dr. Miller explains that most burn centers have switched to digital pictures of wounds be-

cause they are easier to store than 35mm slides. The photography department at Miami Valley Hospital Regional Adult Burn Center makes 3 x 3" glossies from digital images that are placed on the patient's chart or stores the images in the central computer. Surgeons consequently can get a quick overview of patients' progress immediately before seeing them simply by calling up the images on the terminal at a nurses' station. "The digitized images are helpful for consultants, who can't always be there when a patient's dressings are coming off. But they need to have some idea of what the patient's burn wounds looked like, so they look at the digital images that were taken over the last however-many weeks the patient has been in the hospital," Dr. Miller said.

The digital images also provide a visual record for rotating surgical residents. "Some patients have been in the hospital four, five, or six weeks before residents come on the service. The digital photographs let the residents see what patients looked like on admission and get a feel for how well they are progressing," Dr. Miller observed.

What Dr. Miller adds to the digital photography program at the Miami Valley Hospital Regional Adult Burn Center is his PDA. He links a small, lightweight, inexpensive (less than \$100) digital camera to his hand-held computer, carries it to the clinic, the hospital room, and the OR, and captures high-quality pictures of burn wounds that can be transmitted directly to his computer system, saved for educational purposes, and entered into the burn registry when he hot synchs the hand-held at the end of the day.

And he doesn't have to worry about losing any of the pictures or other data. A few months ago, he dropped his PDA and had to replace it with a new one. When he hot synched the new device with his computer system, he was able to completely restore his address lists, memos, documents, and burn care database in three or four minutes. "It would have been a lot harder to reestablish that information if I'd kept it in a little book and lost that book," he said.

Reducing errors

One of the greatest potential uses of PDAs, many proponents say, is to decrease errors, particularly in prescribing medications. According

Companies offering PDA software packages for surgeons

Accenture

www.accenture.com
617/454-4000

Allscripts Healthcare Solutions

www.allscripts.com
800/654-0889

DigitalAssist

www.digitalassist.net

ePhysician

www.ePhysician.com
650/314-2000

ePocrates, Inc.

www.ePocrates.com
650/592-7900

ePhysician

www.ePhysician.com
650/314-2000

Eurekah.com

www.Eurekah.com
512/863-7762

F.A. Davis

www.fadavis.com
800/523-4049

HealthTech Solutions

www.htsolutions.com
314/994-3030

iScribe

www.iscribe.com
650/381-2155

MDeverywhere, Inc.

www.mdeverywhere.com
919/484-9002

Medical ChartWriter

www.chartwriter.com

Pocket Med

www.pocketmed.org
434/825-0099

Pocket Patient Billing

http://pocketpa.imrac.com

Pocketscript

www.pocketscript.com

Skyscape.com

www.skyscape.com
978/562-5555

concluded a survey of 870 physicians who used the qRx hand-held computer drug reference guide by Brigham and Women's Hospital, Boston, MA. The survey, which was presented at the annual meeting of the American Medical Informatics Association in November 2000, showed that 81 percent of the physicians felt they were making better decisions about medications, and 80 percent were better informed about medications. Forty-six percent of physicians reported that the hand-held drug reference guide influenced three or more of their drug decisions every week, and 50 percent said it prevented at least one adverse drug event a week.³

PDA programs that create and transmit electronic prescriptions to pharmacies, such as those from ePhysician, Inc., Mountain View, CA, Allscripts Healthcare Solutions, Inc., Libertyville, IL, Pocketscript Inc., Cincinnati, OH, and iScribe, Redwood City, CA, also prevent drug mix-ups due to handwriting errors. In anecdotal studies conducted by the consulting firm Accenture, Boston, MA, PDA electronic prescription services cut the number of calls from pharmacists to physicians for clarification of a medication order by 20 percent.⁴

Electronic drug reference programs are helpful for surgeons, who tend to prescribe a small number of specific drugs or drug classes and consequently have to look up information about unfamiliar medications, said Barklie Zimmerman, MD, FACS, a vascular surgeon from Richmond, VA. Although the *PDR* is the primary reference for determining dosage patterns, indications, potential adverse effects, and drug interactions, it

to the widely quoted 1999 Institute of Medicine report, at least 44,000 patients in the U.S. die every year because of preventable medical errors, including approximately 7,000 who die of mistakes related to ordering and dispensing medications.²

PDA-based drug information guides may prevent medication errors by increasing clinicians' knowledge about available drugs and improving their selection of appropriate medications,

often provides more data than surgeons need, and it is not always current.

However, the ePocrates qRx program for PDAs is updated every day by an editorial board of physicians, and it includes the name, class, indications, dosage, known drug interactions, adverse events, the mechanism of action, retail price, and package/tablet description of a drug. Other drug-related software for PDAs, such as iFACTs (Drug Interaction Facts) from Skyscape.com, Hudson, MA, provides information about drug-drug and drug-food interactions for more than 2,700 brand name and generic medications in 70 therapeutic classes. The *Johns Hopkins Antibiotic Guide* from Johns Hopkins Medical Center, Baltimore, MD, and qID™, also from ePocrates, identify the proper antibiotic for a specific diagnosis and infecting pathogen.

Such programs give surgeons rapid access to comprehensive, current information about medications from a manageable, portable container. As plastic surgeon Roger Simpson, MD, from Garden City, NY, said, "If I'm in the office or at the bedside, and a patient or another physician asks about a specific medication, and I don't know the dosages, within 20 seconds I can get the dose ranges and contraindications. If a patient is on multiple medications and there may be a problem with a drug interaction, I get a 'doc alert' message as soon as I open the PDA. If patients ask whether they can take an anti-inflammatory when they're also taking asthma medications, I can pull out the PDA and look up contraindications and sensitivities."

If infectious disease specialists are recommending unusual antibiotics, Dr. Simpson doesn't have to take the time to research them all. "I can't believe it, but I can get all that information and keep it in my pocket."

Nonetheless, many surgeons have yet to discover the advantages of using PDAs within their practices. Most physicians, as well as the facilities at which they work, still use laptops and desktops to access Web portals, update records, and send e-mail messages. "The lowest common denominator is an Internet connection and a browser. Everyone has that," Dr. Krusch said. "The next logical leap is porting part of that, taking segments of the functionality of the Web, and applying it to the hand-held device."¹ 

This article was generated through efforts of the Board of Regents' Committee on Informatics. Members of the committee believe that this and other articles published in the *Bulletin* will serve to alert Fellows of the College to and inform them about trends in information technology that will help them simplify the administrative burdens of surgical practice, heighten their use of online and other innovative approaches to CME, and enhance their ability to improve patient care.

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Liability premium increases may offer opportunities for change

by Christian Shalgian,
Senior Government Affairs Associate,
Division of Advocacy and Health Policy

Division of Advocacy and Health Policy

Recent national news reports have speculated that the surge in malpractice insurance premiums could lead to a crisis in the availability of health care services. What is being done to stem this tide? Is this a problem that each state should attempt to solve on its own? Or is this a national problem that should be addressed by the federal government?

Some physicians are now having trouble obtaining medical malpractice insurance, and those surgeons who are fortunate enough to find it are often charged rates that are substantially higher than in previous years.

These alarming rate hikes are not limited to large cities. In Portland, OR, general surgeons saw their malpractice premiums increase by as much as 55 percent. In Charleston, WV, general surgeons experienced premium increases of up to 32 percent.¹

While specific data are not yet available for 2002 premiums, surgeons have reported increases at even higher rates.

Carriers leave the business

The rising cost of offering medical malpractice insurance has not only led to large rate hikes, but has also prompted some companies to leave the medical malpractice insurance market. The greatest impact on physicians may be felt by the departure of St. Paul Companies from the market. On December 12, 2001, St. Paul, the second largest medical malpractice insurer in the country, announced that it would withdraw from the medical malpractice business. According to St. Paul, "The company is forecasting that medical malpractice will generate a 2001 underwriting loss of approximately \$940 million."²

Physicians change practices

The combination of rising insurance costs and decreasing insurance availability is reportedly causing some physicians to retire early, relocate, or drastically change their practices. The *Washington Post*, for example, recently ran a story about physicians in Mississippi who are being forced to drop obstetrics from their practices because of prohibitive increases in their malpractice insurance costs.³ It also has been reported that a group practice in Delaware County, PA, will no longer perform surgery or take trauma call because they can't afford the malpractice insurance. One could speculate that the combination of a resurgent malpractice premium crisis and the continuing downward spiral in payments for key surgical services will lead to a proliferation of stories like these.

National tort reform

To help control the premium increases, the College has been urging Congress to pass a series of medical liability reforms. In fact, six times in the past 10 years, the U.S. House of Representatives has passed these reforms as provisions of other health care-related bills. The efforts to pass national medical liability reform has not found as much support in the Senate, however, where no reforms have been passed to date.

Most recently, the issue of medical liability reform was brought before the House in the summer of 2001, during debate on the Patients' Bill of Rights (PBR). The leading PBR proposal contained provisions that would allow patients to sue their health plans in certain circumstances. While

this provision was controversial, it led to a compromise that included a cap on noneconomic damages for lawsuits brought against health plans. The College and other leading health care groups subsequently argued that a cap on health plan liability would lead to situations where physicians were left with the "deep pockets." To alleviate this inequity, Rep. Bill Thomas (R-CA) introduced an amendment that included all of the medical liability reforms the College supports. Unfortunately, the amendment failed by a vote of 207 to 221.

In addition to the Thomas amendment, legislation on this topic has been introduced by Reps. Jim Greenwood (R-PA) and Patrick Toomey (R-PA). Legislation to put in place needed medical liability reforms also has been introduced by Sen. Mitch McConnell (R-KY).

State tort reform

States have had varying degrees of success in passing medical liability reforms. For some, legislative victories have been tempered by rulings from state supreme courts that have found some medical liability reform laws unconstitutional.

In 1975, the California legislature passed a series of tort reforms that are known collectively as the Medical Injury Compensation Reform Act (MICRA). These reforms included a \$250,000 cap on noneconomic damages, modifications to the collateral source rule, mandatory periodic payments of future damages, and a sliding scale for plaintiff attorneys' contingency fees. MICRA has been challenged a number of times, and in each case the California State Supreme Court has upheld the law.

Other states have not fared as well, however. For example, the Ohio legislature passed a series of medical liability reforms that were later found to be unconstitutional by the state's Supreme Court.

Supporters of medical liability reform have been unable to convince the Pennsylvania legislature to place a cap on noneconomic damages, which many believe is the crucial aspect of liability reform. Since the 1970s, that state has had a mandatory professional liability catastrophe fund. All Pennsylvania physicians pay into this fund, which is used to pay awards and claims that are not covered entirely by malpractice insurance. Due to the recent increases in jury awards, however, large shortfalls threaten the fund.

Medical liability reforms supported by the College

1. Capping noneconomic damage awards, preferably at \$250,000.
2. Modifying the collateral source rule to reduce the total awards by amounts from other sources, such as health insurance companies.
3. Shortening the statute of limitations for filing claims.
4. Limiting attorneys' contingency fees.
5. Eliminating joint and several liability, so a physician who is only partly at fault for an injury cannot be held liable for paying the entire judgment.

Some liability analysts describe West Virginia as "Tort Hell."⁴ Because of the growing medical malpractice crisis in that state, the governor recently called the legislature into a special session in an effort to find a solution to the problem. The legislature passed a series of short-term solutions, but was unable to address the long-range implications of the issue and is expected to consider a variety of potential solutions in 2002.

Other dimensions

Rising malpractice premiums are due at least in part to the large jury awards in many medical malpractice cases. According to Jury Verdict Research, the median award in a medical malpractice case has risen by 113 percent since 1994.⁵ This increase stands in stark contrast to the change in the consumer price index, which has risen approximately 20 percent in the same time period.⁶ An old problem, it has been speculated that the escalation in awards has only been made worse by the size of the awards granted in tobacco lawsuits in recent years.

At the same time that malpractice-related costs are rising, payments to physicians that are intended to reimburse them for these costs have not kept up. The Medicare physician fee schedule, which serves as the foundation for reimbursement rates under both public and private health plans, includes three components: physician work, prac-

tice expenses, and malpractice expenses. The foundation of the entire fee schedule is the principle that physician reimbursement should be based on the relative amount of resources required from them to provide each service.

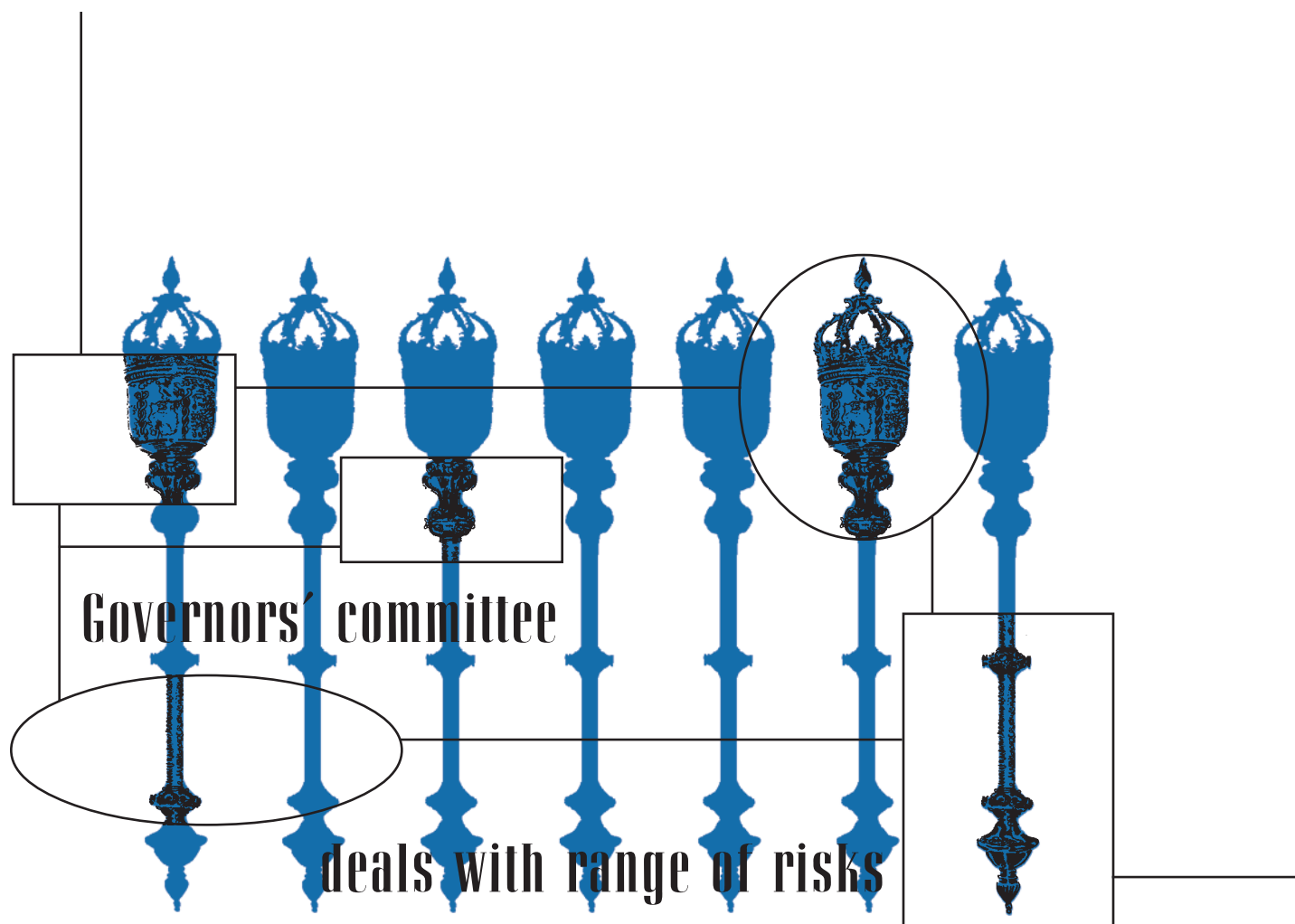
The malpractice expense component represents the smallest fee schedule component, however, accounting for approximately 2 to 3 percent of the average service payment. The relative "weight" given to this component has in fact decreased since 1999, when it accounted for 5 percent of payments on average. This increase is small compared to increasing malpractice insurance premiums, which in many instances have been much gone up by more than 5 percent. Despite this rising cost to physicians, Congress has not allocated any new funds to fairly compensate them for this expense.

Where do we go from here?

Across the country, medical malpractice costs are skyrocketing and physicians are being forced to react. It is clear that efforts are needed at both the national and the state levels. It also is clear that creative thinking is necessary and a variety of solutions beyond the tort reforms that physicians have been promoting for many years will need to be developed. ACS leaders, including the Regental Committee on Patient Safety and Professional Liability and the Board of Governors' Committee on Physician Competency and Liability, are committed to this task, and the College continues to work with surgical specialty societies and through state and national coalitions to address this growing concern. Q

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by Donald E. Fry, MD, FACS, Albuquerque, NM

Editor's note: This article is the fifth in a series of articles that highlight the work of the committees of the Board of Governors (B/G). It focuses on the Committee on Blood-Borne Infection and Environmental Risk.

The spread of lethal pathogens has been an issue of concern to all surgeons throughout the history of our profession. For the last few decades, physicians have been particularly concerned about the possible transmission of HIV, hepatitis B and C, and, most recently, diseases that could be spread through chemical or biological warfare. The College's activities related to monitoring and managing these types of conditions fall under the purview of a group of surgeons now known as the Governors' Committee on Blood-Borne Infection and Environmental Risk.

The panel originally was simply a subcommittee of the B/G Committee on Surgical Practice in Hospitals—the Subcommittee on AIDS. As the group quickly demonstrated its capacity to study

issues and offer solid proposals for managing them, the Board of Governors agreed to make it a standing committee of the Board of Governors in 1992, and it became the Governors' Committee on AIDS.

The committee soon started to study and comment on the transmission of other infectious diseases, and in 1994, we became the Governors' Committee on Blood-Borne Pathogens. To reflect an ever-broadening scope of topics, in 2001, we attained our current moniker.

This article summarizes what the Committee on Blood-Borne Infection and Environmental Risk, in its various manifestations, has done to date and what we plan to accomplish in the future.

Background

In 1981, the first AIDS-related deaths in the U.S. were reported. Throughout the 1980s, surgeons' concerns about HIV infection remained prominent. Blood was handled with suspicion, surgical team members were apprehensive about treating high-risk patients, and the public was concerned

about possible HIV exposure in health care facilities. Hence, in 1989, at the request of the B/G Committee on Surgical Practice in Hospitals, the Board of Governors called upon the College to adopt a position on testing for HIV infection. In considering the Board of Governors' request, the Board of Regents recommended the formation of a Subcommittee on AIDS that would report to the B/G Committee on Surgical Practice in Hospitals. The subcommittee became active in 1990 and was charged with studying, providing educational materials, and developing proposals regarding future College activity related to the AIDS issue.¹

The subcommittee, initially chaired by LaMar S. McGinnis, Jr., MD, FACS, was an active one right from the start. In 1991, the subcommittee developed the College's Statement on the Surgeon and HIV Infection, which was approved by the Board of Regents in October 1991 and issued in December. The statement indicated that: (1) surgeons have the same ethical obligation to treat patients with HIV as they have for other patients; (2) surgeons should use scientifically accepted methods of infection prevention; (3) because there had been no documented instances of a surgeon transmitting HIV to a patient, HIV-infected surgeons may continue to practice and perform invasive procedures unless there is clear evidence that a surgeon is not meeting basic infection control standards or is incapable of providing care; and (4) relevant College committees should continue to consider the concerns of HIV-infected surgeons and their families.²

The document was updated several years later, and the revised text was published in the February 1998 *Bulletin*. In this updated statement, the College noted that the risk of transmission from surgeon to patient and from patient to surgeon remained extremely low. Even so, the federal government continues to expect surgeons to follow guidelines that are costly and inappropriate in the surgical environment. The College also reiterated its belief that "enforcing a high standard of infection control and universal precautions remains the best strategy for protecting patients from accidental exposure," as well as its four points set forth in the original Statement on the Surgeon and HIV Infection.³

Additionally, each year since 1991, we have sponsored a session during the Clinical Congress. Top-

ics that have been addressed during these programs include: AIDS and the Surgical Team, Transmission of Blood-Borne Disease in the Care of Patients: Current Perspectives; Prevention and Treatment of HIV and Hepatitis B and C in the Surgeon and the Health Care Worker; and Surgical Aspects of the Patient with HIV: Etiology, Diagnosis, and Treatment.

Also since 1991, we have maintained a strong relationship with the Centers for Disease Control (CDC). We forged this alliance to ensure that surgeons would be able to offer their input on issues related to HIV and other blood-borne infections before policies are made. In 1994, under the chairmanship of Robert S. Rhodes, MD, FACS, the committee assisted the College in developing a joint conference with the CDC titled Prevention of Transmission of Blood-Borne Pathogens in Surgery and Obstetrics. More than 200 individuals attended the meeting, which was described in considerable detail in the May 1994 *Bulletin*.

One initiative that emanated from the joint conference was the College's Statement on the Surgeon and Hepatitis B Infection. The College decided it was important to focus on HBV in recognition of the fact that "surgeons are at considerable risk for occupational infection from HBV." The statement was published in the May 1995 issue of the *Bulletin*. The committee updated the statement in 1997 to include information about the risks of transmitting and recommendations for controlling HCV. The updated document was renamed simply the Statement on the Surgeon and Hepatitis and was published in the April 1999 issue of the *Bulletin*.

Recent activity

I have served on the committee literally since its inception, first as an ex officio, then as a Governor appointee, and, since October 2000, as Chair. Soon after I became Chair, we changed the name of the panel to the Governors' Committee on Blood-Borne Infection and Environmental Risk. The name change reflects our belief that blood-borne risks in the operating room remain of considerable concern to surgeons and other health care practitioners. Also of great interest over the last few years to several members of the committee, including Kenneth L. Mattox, MD, FACS, Maj. Gen. John Sutherland Parker, MD, FACS, and myself, however, has been the potential use of chemical,

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biological, and nuclear weapons for the purposes of mass destruction. By adding the phrase “environmental risk” to our title, we have demonstrated that our mission has expanded to encompass the development of suggestions on how to deal with these threats to surgeons and their patients.

In light of the terrorist attacks on the U.S. on September 11, 2001, disseminating information regarding unconventional weaponry has now become an even higher priority for the committee and the College in general. We really want to serve as a vehicle for motivating Fellows to become actively involved in overcoming the effects of terrorism at the local level.

During the 2001 Clinical Congress, I participated in a special session on Unconventional Civilian

Disasters: What the Surgeon Should Know with David B. Hoyt, MD, FACS, Chair of the College's Committee on Trauma. During the program, I presented information substantiating and summarizing the College's Statement on Unconventional Acts of Civilian Terrorism. The committee crafted this document, which was subsequently approved by the Board of Governors and the Regents and published in the November 2001 *Bulletin*.

In the statement, we noted that there are three major categories of unconventional acts of civilian terrorism (ACTs), including: nuclear/radiation events, such as nuclear detonation, radioactive explosions, and dissemination of radioactively contaminated food and water; chemical events, such as dispersion of cyanide, sarin, and so on; and bio-

logical events, including the spread of anthrax, brucellosis, and cholera.

The statement makes clear that it is of the utmost importance that surgeons develop a new level of knowledge so they can care for patients who are casualties of these actions. Specifically, we recommend that: (1) Fellows of the College actively participate in local and regional disaster-planning; (2) Fellows attain extensive education and training in the pathogenesis, diagnosis, prevention, and treatment of the likely agents of unconventional ACTs; (3) Fellows educate other health care practitioners and the nonmedical community about the effects of ACTs and how to treat them; (4) the College accept a policy of universal standards for responding to all potential terrorist activity; and (5) the College develop formal relations with disaster planning and response units.

The statement is just the first in what we anticipate will be a long line of informational materials that we will prepare on this subject. This year, for example, we plan to publish an article in the *Journal of the American College of Surgeons* on the effects of chemical and biological agents. Additionally, we are preparing a program in conjunction with the ACS Committee on Trauma on Weapons of Mass Destruction in a Civilian Setting for presentation at this year's Clinical Congress.

In addition, the committee is working on an emerging issue—nosocomial transmission of prion, the infectious agent that causes mad cow disease. Over 250 patients have contracted nosocomial prion infection from the receipt of neurografts, or from contaminated surgical instruments that had previously been used on patients subsequently shown to have prion infection. We have discovered that there is a risk of transmission from surgical instruments, even when appropriate sterilization has been used. In some cases, the instruments may need to be destroyed. This growing problem raises some very interesting issues for all surgeons, and the committee plans to publish an article regarding the transmission of prion disease in the *Journal of the American College of Surgeons* later this year.

Of course, we continue to pay close attention to HIV and hepatitis infection among health care workers and to update the College on its transmission. Between October 2000 and October 2001, there were seven additional possible cases of HIV

transmission among health care workers and no new documented cases. No documented transmissions occurred among surgeons, and no transmissions occurred from solid needle injury since the onset of the HIV epidemic in the U.S. With regard to hepatitis, there were no new cohorts of HBV transmission from surgeon to patient and one reported cohort of HCV transmission from a gynecologic surgeon.

Conclusion

The B/G Committee on Blood-Borne Infection and Environmental Risk has consistently foreseen issues that are likely to be of concern to surgeons and responded in a timely and an appropriate manner. It's very exciting to be part of a committee that is carrying out many innovative activities and that has the potential to do some good both for surgeons and the patients for whom they care.

I would like to gratefully acknowledge the contributions of all the committee members (see roster, p. 27). We all look forward to carrying out our current mission and to helping the College meet future challenges. □

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Dr. Fry is professor of surgery and chairman of the department of surgery at the University of New Mexico. He also is Chair of the ACS Governors' Committee on Blood-Borne Infection and Environmental Risk.



A summary of the Ethics and Philosophy Lecture

SURGERY

Is it an impairing profession?

Editor's note: The following is a summary of the Ethics and Philosophy Lecture delivered by Thomas J. Krizek, MD, FACS, during the 2001 Clinical Congress in New Orleans, LA. Dr. Krizek is professor of religious studies and professor of surgery and medicine (ethics) at the University of South Florida, Tampa. The text of Dr. Krizek's presentation will appear in its entirety in the March 2002 issue of the Journal of the American College of Surgeons.

Dr. Krizek posed the question, "Surgery: Is it an impairing profession?" during the Ethics and Philosophy Lecture at the 2001 Clinical Congress. To this query he responded, "I believe we may be an impairing profession, but we don't have to be."

The evidence that surgery may be an impairing profession can be found in data indicating that the rates of alcoholism, drug addiction, emotional disease, and divorce are all higher among surgeons than the rest of society. Dr. Krizek, a recovering alcoholic, defined impairment among surgeons as being "no longer capable of performing in a professionally safe fashion."

Dr. Krizek said that the profession of surgery and surgical training programs must change in order to reduce the risk of impairment. Particularly important, he said, are changes in the educational process, because it is during training that surgeons develop both good and bad habits.

Dr. Krizek offered 10 observations on what factors involved in the surgical training process are impairing. They are as follows:

1. The length of training is too long. Dr. Krizek added that all surgical trainees must complete programs of predetermined duration, but what they learn may vary. "The constant is time, and the variable is quality," he said. "We have the wrong constant and the wrong variable." Further, he noted that more and more surgeons are retiring in their 50s because of the pressures associated with the profession. Because surgeons don't complete their training until they are in their mid-30s, they can

only practice for about 20 years. If the length of training were reduced, residents could look forward to longer and more productive careers.

2. The financial sacrifice is too great. He said residents should earn a living wage and pay tuition. If they earned a reasonable amount of money during their residencies, they would be more likely to "give back" to the system that trained them after their practices get off the ground and should be expected to do so.

3. The hours of work are too many. Work hours should be devoted primarily to learning. Unfortunately, surgical residents are currently admired and rewarded for simply working longer hours.

4. Sleep deprivation is dangerous. He noted that lack of sleep distorts thinking and is incompatible with learning.

5. Surgery is emotionally draining. "Socially virtuous professions use up emotion," Dr. Krizek said. Residents are often the ones who must explain to family members why a patient died during an operation. "Residents nurture. Who nurtures them?" he noted.

6. There is a "tragic need to suppress emotions." Residents are taught to "suppress secrets, hide grief, and deal with challenges to honesty and integrity," he said.

7. Fragmentation of surgeons begins early. Residents are segregated on the basis of the specialty they choose, and these divisions continue throughout their careers.

8. Mistakes are not handled appropriately. They usually are handled with silence, disapproval, or accusations of liability.

9. Impairment may be behavioral, the result of injury, or the product of chemical dependency. It is important that surgeons reach out to impaired residents and colleagues. "Why should we do it?" he asked. "Because they can't do it alone."

10. If the training process is changed, the profession will reap rewards. "The seeds of impairment are planted during residency," Dr. Krizek added. What fruit those seeds will bear is up to the profession, he concluded.

Statement on bicycle safety and the promotion of bicycle helmet use

At its October 2001 meeting, the Board of Regents approved the following statement, which was developed by the Subcommittee on Injury Prevention and Control of the College's Committee on Trauma.

The American College of Surgeons and its Committee on Trauma recognize the importance of injury prevention in the spectrum of care of the trauma patient, especially with regard to the prevention of traumatic brain injury. Cycling remains an important means of transportation and recreation; however, the bicycle rider can be at significant risk of serious injury.

The College recognizes the following facts:

- Approximately 800 people die and 17,000 are hospitalized in the U.S. due to bicycle-related injuries. Bicycle crashes are the fourth largest contributor to childhood injury costs and quality-of-life losses.
- Bicycle injuries account for the largest number of sports-related injuries treated in emergency departments.
- Bicycle helmets can reduce the risk of head injury by 85 percent. Bicyclists hospitalized with head injury are 20 times more likely to die than those without head injury.
- 98 percent of bicyclists killed were not wearing a helmet at the time of injury. Helmet use is estimated to prevent 75 percent of cycling deaths.
- As of November 2000, bicycle-related injuries and deaths had decreased in the 17 states that have youth bicycle helmet laws.
- Helmets can benefit adult riders as well as children. As more helmet laws target youth, the proportion of adults comprising bicycle fatalities has risen from 32 percent in 1975 to 71 percent in 1999.
- Helmet laws are necessary. Forty-three

percent of bicyclists report that they *never* wear a helmet, and of those who do, 44 percent report that they do so only because a law requires it.

Therefore, supported by these and other epidemiologic and outcomes data, the American College of Surgeons supports efforts to promote, enact, and sustain universal bicycle helmet legislation. 

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Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first Web-based and only continuously updated surgical reference. Chapters may be viewed in their entirety by visiting the online version of *ACS Surgery: Principles and Practice* found on the physician portion of the WebMD Web site at www.webmd.com.

VIII. Common Clinical Problems

8. *Lower Gastrointestinal Bleeding*. Michael Rosen, MD, Jeffrey L. Ponsky, MD, FACS. In this chapter, the authors review the wide array of etiologies of lower gastrointestinal bleeding (LGIB), as well as the diagnostic and therapeutic modalities available to treat this difficult clinical problem. Tenets of management include initial hemodynamic stabilization followed by localization of the bleeding site, and then eventual, site-specific therapeutic intervention. There are many causes of LGIB, and successful localization requires timely and appropriate use of a variety of diagnostic tests. Diverticular disease is the most common cause of LGIB and represents 30 to 40 percent of all cases. While arteriovenous malformations are extensively

described in the literature, their actual incidence as a cause of LGIB is reported at 1 to 4 percent in several large series. Other causes of LGIB include inflammatory bowel disease, benign and malignant neoplasms, ischemia, infectious colitis, anorectal disease, coagulopathy, NSAIDs use, radiation proctitis, AIDS, and small bowel disorders. While the ultimate decision on what tests to order are based on the individual case, the authors recommend beginning the work-up for lower GI bleeding with a colonoscopy when possible. If a source is not identified, then an upper endoscopy should follow. If the source of the bleeding still remains obscure or if massive hemorrhage precludes safe endoscopic examination, then angiography or nuclear medicine scans might be appropriate. Finally, every effort to accurately identify the source of bleeding should be made before surgical resection. Therapeutic options for the clinician include endoscopy, angiography, or surgery.

The full text of "Lower Gastrointestinal Bleeding" may be viewed at www.webmd.com. Click on *ACS Surgery: Principles and Practice*.

XI. Surgical Techniques

1. *Gastrointestinal Endoscopy*. Alicia Fanning, MD, Jeffrey L. Ponsky, MD, FACS. Since the beginning of the 1970s, flexible endoscopy of the gastrointestinal (GI) tract has been the dominant modality for the diagnosis of gastrointestinal disease. Over the same period, developments in technology and methodology have made possible the use of endoscopy to treat a host of conditions that once were considered to be manageable only by means of open surgical procedures. The integration of flexible endoscopic techniques into the armamentarium of the GI surgeon permits a more multidimensional approach to the treatment of

continued on page 38

Monthly updates to the online version of *ACS Surgery: Principles and Practice* in the physician portion of the WebMD Web site, www.webmd.com, are also available quarterly through subscription to the *ACS Surgery* CD-ROM, which incorporates every online update from the previous three months and yearly through subscription to the annual hardcover edition of *ACS Surgery: Principles and Practice*, which incorporates every online update from the preceding year. To learn more, visit the *ACS Surgery: Principles and Practice* page on the ACS Web site, www.facs.org/members/acs_surgery.html.

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

College news

Dr. Harken named to ACS executive staff

ACS Executive Director Thomas R. Russell, MD, FACS, has appointed Alden H. Harken, MD, FACS, to the executive staff of the College as volunteer Interim Director of the Division of Research and Optimal Patient Care.

As Interim Director of the division, Dr. Harken will oversee the activities of the Office of Evidence-Based Surgery and of the Cancer and Trauma programs of the College. Through this division, the College will advance the practice of surgery through research and scholarly activities to expand medical knowledge by: providing opportunities for scholarships and fellowships; education of surgeons about funding and research-related activities, such as clinical trials and outcomes efforts; and development of strategies to improve philanthropic activities.

Dr. Harken is professor in the department of surgery at the University of Colorado, Denver. He has been a Regent of the College representing cardiothoracic surgery since 1999, and is a member of the Board of Regents' Executive Committee and Fellowship Liaison and Honors Committees. He is the Regental representative to the Advisory Council for Cardiothoracic Surgery and Chair of the College's Scholarships and Surgical Research and Education Committees. Dr. Harken is also an Editorial



Dr. Harken

Advisor for the *Bulletin*.

A Fellow since 1978, Dr. Harken has been active in a wide range of College activities. He served on the Pre- and Postoperative Care Committee (1982-1985, senior member, 1988-1992), the Committee on Young Surgeons (1983-1986), and the Committee on Continuing Education (1987-1990).

Dr. Harken graduated from Harvard College in 1963 and obtained his medical degree from Case Western Reserve Medical School in 1967. He was intern (1967-1968), junior resident in surgery (1968-1970),

and senior and chief resident in surgery (1971-1973) at Peter Bent Brigham Hospital, Boston, MA. He served as chief of cardiovascular physiology at Walter Reed Army Institute of Research, Washington, DC, from 1974 to 1976.

Dr. Harken was assistant professor, associate professor of surgery, and professor of surgery at the University of Pennsylvania, Philadelphia, from 1976 to 1984. He assumed his duties as professor of surgery and chair of the department of surgery at the University of Colorado, Denver, in 1983. Since 1984 he has also served as chief of surgery, University Hospital, and staff surgeon at Veterans Administration Hospital, Rose Medical Center, The Children's Hospital, and Denver Health Medical Center—all in Denver, CO.

Dr. Harken has served as president of the Association for Academic Surgery, the Society of University Surgeons, the Colorado Trauma Institute, and as director of the American Board of Surgery and the American Board of Thoracic Surgery. He holds membership on the editorial boards of the *Journal of Surgical Research*, the *Journal of Cardiac Surgery*, *Archives of Surgery*, *Surgery*, *Shock*, and the *Journal of Thoracic and Cardiothoracic Surgery*. He is also an editor of *ACS Surgery: Principles and Practice*.

2001 Australia-New Zealand Chapter Travelling Fellowship

by William M. Kuzon, Jr., MD, PhD, FACS, Ann Arbor, MI

It was an honor to be selected as the 2001 Australia-New Zealand (ANZ) Chapter of the ACS Travelling Fellow. My personal academic enrichment as a result of the fellowship has been enormous, and I can only hope that I have replied in kind during my travels in the past three months.

Australasian College meeting

In May 2001, I attended the annual scientific congress of the Australasian College of Surgeons in Canberra, ACT. This week-long meeting featured an outstanding scientific program, generous collegiality, and a busy social schedule. During the meeting, I delivered the 2001 American College of Surgeons Lecture, participated in three open panel discussions, spoke at the annual ANZ ACS Chapter luncheon, and delivered two free communications. The titles of these panels were:

- An Algorithmic Approach to Facial Palsy.
- International Surgeons' Forum: Surgeons Beyond 2000.
- Facial Paralysis.
- Plastic Surgery Education.
- Workforce Issues Facing the Young Plastic Surgeon in the U.S.
- Plastic Surgery Training in the U.S. and Canada.
- Trauma Surgeons Are from Mars, Reconstructive Surgeons Are from Venus.



Dr. Kuzon

Traveling portion

In July 2001, I returned to Australia with my family to fulfill the traveling portion of the fellowship. We arrived in Melbourne on July 10. The next day, I visited Mr. Felix Behan and the house staff at the Western Hospital in Melbourne. Mr. Behan had generously arranged an outpatient clinic for me to examine patients who had undergone reconstructions with his fasciocutaneous island flap technique. We made ward rounds at the hospital, and I observed an intraoral reconstruc-

tion in the operating theater. I also had an opportunity to visit Mr. Behan's private office, and I read and edited a manuscript on his fasciocutaneous flap technique that he is submitting for publication.

The next morning I was fortunate enough to attend ward rounds at the Royal Melbourne Hospital with Mr. Bruce Johnstone and Mr. G. Ian Taylor. After a teaching session with residents and attendings where I spoke on facial reanimation, I attended outpatient clinic with the plastic surgery staff. I was also able to spend several hours with Mr. Taylor in his research suite where we had a lively exchange of ideas.

In the afternoon on July 12, I visited St. Vincent's Hospital in Melbourne where I observed Mr. Wayne Morrison perform a microvascular nasal reconstruction. I was then able to attend their plastic surgery outpatient clinic and to participate in ward rounds at St. Vincent's Public Hospital. I enjoyed a tour of the research facilities at the Bernard O'Brien Institute of Microsurgery, hosted by Mr. Morrison. At the institute, I delivered a lecture on tissue engineering to attendings and residents from several Melbourne hospitals. As a result of my visit, it is likely that Mr. Morrison and I will begin a research collaboration in the area of tissue engineering.

Next, I visited the Royal Children's Hospital, Melbourne, with Mr. Christopher Coombs serving as my host. I was able to participate in a micro-neurovascular gracilis transfer for the reanimation of the face of a child with Mobius syndrome that Mr. Coombs performed on that day. As a result of our common interest in facial reanimation, Chris and I will be coauthoring a review paper on this topic for an upcoming issue of *Plastic Surgery Clinics of North America*.

Also on July 13, I was able to visit the research laboratory of Dr. Gordon Lynch, a lecturer in physiology at the University of Melbourne. Dr. Lynch and I have a common research interest in the area of skeletal muscle mechanical function, and we plan to collaborate on an examination of mechanical dysfunctions in skeletal muscle after neurovascular transfer and distraction osteogenesis.

After traveling for several days by car, we arrived in Adelaide on July 15, 2001. On July 16, I visited Flinders Medical Centre. Mr. Ian Leitch and Mr. Nicholas Marshall were our hosts. After morning ward rounds, I spoke at a conference attended by plastic surgery staff and house officers that highlighted cultural differences in the practice of plastic surgery between the U.S. and Australia. I was able to attend their outpatient clinic that morning, and I had a chance to interact with their house staff throughout the day.

On July 17, I was honored to lead a teaching session for all plastic surgery residents in Adelaide. The program, orga-

nized by senior registrar Dr. Peter Riddell, was held at Queen Elizabeth's Hospital in Adelaide. This half-day session focused on peripheral nerve injury and repair. We examined a patient with a newly diagnosed brachial plexus lesion and discussed the management of this problem in detail. We reviewed the physiology of nerve regeneration and covered the management of peripheral nerve injuries in detail. I gave a formal talk on the management of facial nerve injuries. I was also able to participate in ward rounds at Queen Elizabeth's that morning.

That evening, I gave a formal lecture at a meeting of the South

Australian Society of Plastic Surgeons. Mr. Leitch was kind enough to arrange this meeting, and I spoke on the intersection between research and clinical practice in plastic surgery. The meeting was attended by attending surgeons and residents from several hospitals in Adelaide.

For the next week, my family and I enjoyed touring Ayers Rock, northern Queensland, and the Great Barrier Reef, arriving in Sydney on July 25, 2001.

While in Sydney, I visited Prince of Wales Hospital with my host, Mr. Mark Gianoutsos. After attending their monthly research conference, I spent the day visiting the Orthopaedic Research Laboratories

Lectures presented

The following citations appear on my curriculum vitae as a result of my visits to medical centers in Australia in July 2001:

Kuzon WM: "Improving Reanimation in Patients with Facial Palsy." Plastic and Reconstructive Surgery Teaching Conference, Royal Melbourne Hospital, Melbourne, Victoria, Australia, July 10, 2001.

Kuzon WM: "Skeletal Muscle and Peripheral Nerve Tissue Engineering." Special Research Seminar, Bernard O'Brien Institute of Microsurgery, Melbourne, Victoria, Australia, July 10, 2001.

Kuzon WM: "Cultural Determinants of Practice in Plastic Surgery." Plastic and Reconstructive Surgery Teaching Conference, Flinders Medical Cen-

ter, Adelaide, South Australia, Australia, July 16, 2001.

Kuzon WM: "The Management of Facial Nerve Injuries." Plastic and Reconstructive Surgery Teaching Conference, Special Resident's Program, Queen Elizabeth Hospital, Adelaide, South Australia, Australia, July 17, 2001.

Kuzon WM: "Can Research Impact Clinical Care in Plastic Surgery?" South Australian Society of Plastic Surgeons, Adelaide, South Australia, July 17, 2001.

Kuzon WM: "Mechanical Dysfunction in Skeletal Muscle: Denervation/Reinnervation, Neurovascular Transfer, and Aging." University of New South Wales Department of Surgery, Sydney, Australia, July 26, 2001.

at the University of New South Wales under the direction of Dr. William Walsh. Drs. Gianoutsos, Walsh, and I are planning a major research collaboration examining the effects of mandibular distraction osteogenesis on the mechanical function of the muscles of mastication. I was able to visit their laboratory and animal facilities, and we spent the day planning our collaboration in detail. This effort will involve investigators at the University of Michigan, Stanford University, The University of Melbourne, and The University of New South Wales. This multicenter project is possible only as a result of the ACS travelling fellowship. After our daylong meetings, I gave an open lecture on our research in the area of mechanical dys-

function in skeletal muscle attended by faculty and students from the University.

The following day, my family and I were able to meet Mr. Stephen Deanne and his wife Ann for dinner, and we recapped my fellowship activities before our departure for home.

Conclusion

In summary, as the 2001 Australia-New Zealand Chapter of the ACS Travelling Fellow, I participated in the Australasian College Congress in Canberra, and visited seven medical centers and three major university research laboratories. I presented 10 talks or lectures, participated in three scientific panels, and interacted with literally dozens of plastic surgeons and plastic surgery house officers. As a re-

sult of my fellowship, two significant research collaborations are planned, and one scientific review article is in preparation. This remarkable academic interaction would not have been possible without the support of the ACS travelling fellowship.

Lastly, I would be remiss if I failed to acknowledge my gratitude for the enormous hospitality that was extended to my family during our travels in Australia. Everywhere we went, we were taken out to dinner, invited into private homes, given driving tours of cities, and shown special attractions. We made many new friends and were made to feel very welcome. It is my sincere hope that I am able to repay that hospitality when my Australian colleagues visit the U.S.

2002 Trauma Motion Picture Session: Call for videotapes

Authors of videotapes on subjects related to trauma (for example, "How-I-do-it," operative techniques of interesting or challenging problems in trauma resuscitation or management) wishing to present their videotapes during the 2002 Clinical Congress in San Francisco, CA, Wednesday, October 9, 1:00-3:00 pm, are encouraged to submit:

1. Preliminary information on the appropriate form, available from Gay Lynn Dykman, Committee on Medical Motion Pictures, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211, tel. 312/202-5262. This form is acces-

sible on the College's Web site, www.facs.org, or by calling the faxback system, at 1-800/329-7833.

AND

2. A 50-word abstract for each videotape.

AND

3. The videotape itself (3/4" U-matic or 1/2" Super-VHS formats).

Submit before **April 5, 2002**, to Rao R. Ivatury, MD, FACS, Department of Surgery, West Hospital, 15 East, P. O. Box 980454, 1200 E. Broad St., Richmond, VA 23298-0454. For further information, call 804/828-7748.



Postgraduate course syllabi now available on CD-ROM

A CD-ROM containing select postgraduate course syllabi from the 2001 Clinical Congress is now available for purchase through the College's Web site at <https://secure.telusys.net/commerce/current.html> or by calling 312/202-5474.

Twenty courses are included on the CD-ROM, which is available for \$35. There is an additional charge of \$12 for shipping and handling for international orders.

The CD-ROM contains syllabi from the following postgraduate courses:

- *Professional Liability and Risk Management in a Changing Health Care Environment*
- *Head and Neck Surgery*
- *Diseases of the Liver, Biliary Tract, and Pancreas*
- *Vascular Surgery*
- *Thoracic Surgery*
- *Current Controversies in Cancer Management*
- *Gastrointestinal Disease*
- *Minimal Access Surgery*
- *Clinical Update in Trauma*
- *Cardiac Surgery*
- *Laparoscopy and Urology*
- *Surgical Infection and Antibiotics*
- *Breast Disease*
- *Pre- and Postoperative Care (Nutritional Support)*
- *Anesthetic Innovations for Improving Surgery and Postoperative Pain Control*
- *Practical Operating Room Management for Surgeons*
- *Complex Hemangiomas and Vascular Malformations*
- *Perioperative Care of the Anemic Patient*
- *Colon and Rectal Surgery*
- *The Anatomy and Surgical Correction of Groin and Abdominal Wall Hernias*

Surgeons targeted for identity theft

The American College of Surgeons has recently become aware of identity theft targeted at surgeons that has included the unauthorized issuance of credit cards and subsequent purchase transactions against the fictitious cards. Although individuals are not legally liable for such purchases, clearing up the problem of identity theft

takes significant time and effort. You can request that a protective statement, which warns creditors to verify identification before opening new accounts in your name, be added to your report. Contact TransUnion, Fraud Victim Assistance Department, at <http://www.transunion.com>, or call 800/680-7289, or write to P.O. Box 6790, Fuller-

ton, CA 92834; Equifax Credit Information, Consumer Fraud Division, at <http://www.equifax.com>, or call 800/525-6285, or write to P.O. Box 740256, Atlanta, GA 30374; or Experian's National Consumer Assistance at <http://www.experian.com>, or call 888/397-3742, or write to P.O. Box 9530, Allen, TX 75013.

State issues database now online

Fellows and College chapters can keep track of proposed state legislation and regulations via a state-issues database at <http://www.facs.org/dept/hpa/state.html>.

The database includes information on dates of a state's leg-

islative sessions, a link to each state legislature's Web site, and bills and regulations of particular interest to surgeons. Users may access this information by state, issue, word (text search), or date of last update. This database is a work in progress, and

some states may have very few listings because of slower regulatory/legislative processes or just released actions currently under consideration. For more information, contact Jon Sutton at 312/202-5358, or e-mail jsutton@facs.org.

KEEPING CURRENT, from page 32

digestive disease. The modern GI surgeon should certainly be conversant in and adept at many of these procedures.

The authors review the following:

- Diagnostic and therapeutic esophagogastroduodenoscopy.
- Variceal and nonvariceal hemorrhage control.
- Dilation of esophageal strictures.
- Stenting of esophageal tumors.
- Retrieval of foreign bodies.
- Percutaneous endoscopic gastrostomy.
- Diagnostic and therapeutic endoscopic retrograde cholangiopancreatography.
- Diagnostic and therapeutic colonoscopy.
- Chromoendoscopy.
- Endoscopic mucosal resection.
- Endoscopic ultrasound.
- The potential of endoscopic suturing.

The full text of "Gastrointestinal Endoscopy"

may be viewed at www.webmd.com. Click on ACS Surgery: Principles and Practice.

Looking ahead

New chapters scheduled to appear as online updates to ACS Surgery: Principles and Practice in the first part of 2002 include "Fast Track Surgery," by Henrik Kehlet, MD, PhD, and Douglas W. Wilmore, MD, FACS; "Open Esophageal Procedures," by Richard Finley, MD, FACS, and John Yee, MD; "Acute Renal Failure," by Anthony A. Meyer, MD, FACS, and Renae Stafford, MD; "Injuries to the Great Vessels of the Abdomen," by David V. Feliciano, MD, FACS; "Jaundice," by Jeffrey Barkun, MD, and Alan Barkun, MD; and "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS. □



Highlights of the Board of Regents meeting

October 5-7, 12, 2001

by John P. Lynch,
Director,
Organization Department

Fellowship

The Regents approved a total of 1,786 Initiates for induction into the College. The Initiates come from the U.S. and its possessions, Canada, and 39 other countries.

Financial reports

The Regents accepted the audited financial statements of the American College of Surgeons as of June 30, 2001, and for the six months then ended, including the independent auditor's report from the firm Deloitte & Touche, LLP.

In another action, the Board approved procedures for the dues approval process. These procedures include annual review of the dues structure by the Board of Regents' (B/R) Finance Committee and the Board of Governors' (B/G) Committee to Study the Fiscal Affairs of the College. The B/R Finance Committee evaluates the dues structure and recommends a proposed structure to the B/G Committee to Study the Fiscal Affairs of the College. The committee evaluates dues proposals from the Finance Committee and forwards its proposals with comment to the Board of Governors as a whole. The Board of Governors evaluates these proposals and forwards its recommendations to the B/R Finance Committee. The Finance Committee reviews comments from the Board of Governors and recommends a dues structure for review and approval by the Board of Regents.

Following this procedure, the Board of Regents approved a dues increase of \$65 for Domestic Fellows (U.S.) and \$15 for Canadian Fellows. This increase was initially approved and subsequently recommended by the Board of Governors at its meeting on October 7. Dues for other membership categories remain the same. The following schedule of rates for the year 2002 was then approved by the Board of Regents based on the rec-

ommendations of the Board of Governors:

- Domestic Fellows (U.S.) and federal: \$440.
- Canadian Fellows: \$335.
- Fellows from other countries: \$155.
- Associate Fellows: \$188.
- Candidate Group: \$20.

NOTE: In a subsequent mail ballot conducted on

October 29, the Board of Regents voted to postpone the dues increase until 2003. This action was taken in light of the terrorist events on September 11, the state of the economy, and news from the Center for Medicare & Medicaid Services (CMS) that all surgeons and physicians can expect an across-the-board payment cut as a result of a reduction in the Medicare conversion factor of 5.4 percent from the current \$38.26 to \$36.19. These reductions will largely offset gains many surgeons were expecting as a result of the recommendations from the AMA Specialty Society Relative Value Scale Update Committee approved by the CMS to increase physician work values for over 240 general surgery codes as recommended by the ACS.

In another action, the Regents approved the actions taken by its Finance Committee providing funding of \$1,532,000 for scholarship and fellowship awards beginning in the year 2002 and 2003. This included funding for a new scholarship, the American College of Surgeons/Royal College of Surgeons of England Research Fellowships Exchange to be sponsored jointly by the two organizations.

Continuation of SESAP

The Regents approved the continuation of the Surgical Education and Self-Assessment Program (SESAP). This program has evolved from a self-assessment tool into an important part of the College's efforts to work with the American Board of Surgery on recertification efforts. The eleventh edition of SESAP was

launched at the 2001 Clinical Congress in New Orleans and will be in circulation for three years.

Proposed VA/ACS partnership on expansion of the NSQIP into the private sector

The Regents approved a standard Consortium Agreement with the U.S. Department of Veterans Affairs (VA) to administer the Agency for Healthcare Research and Quality (AHRQ) grant of \$5.25 million to evaluate the VA's National Surgical Quality Improvement Program (NSQIP) as a reporting system to improve patient safety in the private sector. The College will test the program in 10 nonfederal hospitals and evaluate the results, and will also evaluate the results of NSQIP previously conducted in 123 VA hospitals. The NSQIP was established in 1994 to expand the work of the National VA Surgical Risk Study in developing and validating risk-adjustment models in 123 VA hospitals that perform major surgery for the prediction of surgical outcomes and the comparative assessment of the quality of surgical care among multiple facilities. The U.S. Department of Veterans Affairs has developed, implemented, conducted, and supported this national data collection and feedback system of risk-adjusted surgical outcomes for the purpose of continuous quality improvement in its surgical service.

If the program proves successful in the private sector, the ACS and the VA could decide at a later date to establish a formal partnership to extend the program nationally. This endeavor should provide important information on patient safety issues in surgery that will have significant implications for ACS Fellows in clinical practice.

Statement on bicycle safety

The Regents approved a Statement on Bicycle Safety and the Promotion of Bicycle Helmet Use, developed by the ACS Committee on Trauma's Subcommittee on Injury

Prevention and Control. The statement, published on page 30 of this issue of the *Bulletin*, emphasizes the College's support of efforts to promote, enact, and sustain universal bicycle helmet legislation.

American Association of Endocrine Surgeons listing

A request from the ACS Advisory Council for General Surgery recommending that the American Association of Endocrine Surgeons be included in the official list of approved surgical societies in the ACS membership directory database was approved by the Board. The society has a total of 276 members, 211 of whom are Fellows of the College.

College participation in Medem

The Board approved the recommendation that the College join with Medem in offering physician Web sites for its members. Medem is a company that assists medical and surgical society members in establishing Web sites for their practices. It also assists medical society members in providing reliable medical information through their Web sites. There are currently more than 30 medical, surgical, and state medical societies offering these services to their members through the capabilities of Medem.

Establishment of New York Chapter

At the request of the Governors from the Upstate New York Chapter, the Regents approved issuing a charter for the establishment of the New York Chapter. Creation of this chapter will help to advance the socioeconomic and educational issues related to surgery in the state by providing a forum for all Fellows in New York State to work in advancing surgical issues. With the formation of this chapter, the Upstate New York Chapter and the New York State Society of Surgeons will dissolve their organizations and meet together under the new organization. There are currently five other chapters in New York State.

ACS Bylaws changes

The Regents approved several changes in the current *Bylaws* of the American College of Surgeons. The majority of the changes are related to the reorganization of the College into four divisions in place of several departments.

ACS branding/marketing program

The decision to vote on a proposal for an ACS branding/marketing program was deferred until the February 2002 Board of Regents meeting in light of the terrorist events of September 11 and the uncertainty of the ultimate impact of these events on the College's financial health. The program would seek to establish a strong brand for "FACS," and would be directed toward two main audiences—the public and the surgical community.

ACS 501(c)(6) organization

The Board of Regents approved in concept the recommendation from its Health Policy Steering Committee for the establishment of a separate ACS 501(c)(6) corporation. Final details concerning establishment of this corporation will be developed by the task force working on this issue and presented for consideration to the Regents in February. The first goal of this new entity would be to facilitate an expanded legislative support program, including the creation of a political program. The new entity would enable the College to create new tools to augment its legislative programs, and to increase the effectiveness of surgery's participation in the legislative process. Other potential activities outside the scope of the ACS Division of Advocacy and Health Policy may be assigned to this new entity in the future as determined by the Board of Regents. These might include an independent management structure to provide administrative services for smaller surgical societies and some College chapters, and new verification or education activities.

The Health Policy Steering Committee and the Board of Governors are both on record in supporting a 501(c)(6) organization. The prin-

cipal interest in establishing this entity originally centered on the need for more flexibility to pursue an enhanced legislative support program that might include the creation of a political action committee. The Board of Regents, in considering the establishment of this entity, emphasized the need to support programs that are consistent with the College's traditional mission and financial interests. The College would retain its 501(c)(3) status, which will include, for the present, responsibility for all ACS activities other than the expanded legislative support program.

Expanded ACS Development Program

A business plan to expand the College's Development Program was approved by the Regents. The plan provides for additional staff, including a surgeon to assume the leadership position of Director of Development. Future program growth is expected ultimately to be funded by increased contributions from Fellows, medical industry, and other organizations. The overall goal of the development program is to raise funds to support the ACS scholarship, research, and education programs approved by the Regents.

ACS strategic plan update

ACS Executive Director Thomas R. Russell, MD, FACS, updated the Regents on the implementation of the *ACS Strategic Plan for 2001 and Beyond*. A copy of the plan was included in its entirety in the September 2001 *ACS Bulletin*, and interpreted further by Dr. Russell in his "From my perspective" column in that issue of the *Bulletin*. Copies of the plan were distributed to the Board of Regents and the Board of Governors at their October meetings. Copies of the plan have also been circulated to all College staff, along with information about the ACS internal reorganization of the staff under four divisions of advocacy and health policy, education, member services, and research and optimal patient care.

These detailed strategic initiatives, which were reviewed, discussed, and approved by the Board of Regents at its June 2001 meeting,

have been distributed to the ACS executive staff for implementation.

For the second phase of the strategic plan, the Regents were updated on the review of the College's standing committees. Letters have been sent to the chairs of all standing committees asking for their personal assessment of the viability and activities of their committees. Comments will be analyzed by College staff, further reviewed by a staff work group, and presented in a report to the Regents in February or June 2002, which will include recommendations relating to the continuation, combination, restructuring, or dissolution of committees, along with suggestions for updating the rules that govern them.

Summary report/ Board of Governors' annual reports

The summary report of the annual reports submitted by the Governors was reviewed by the Regents. The report outlined the concerns of Fellows regarding specific surgical and health-related issues at the national and local levels, and identified specific recommendations for College programs to meet these concerns. This year, 233 of the College's 265 Governors (88%) submitted reports.

The Regents also reviewed the response report presented to the Governors by Barbara L. Bass, MD, FACS, Chair of the Board of Governors, at the Governors' annual meeting on October 7. The report outlined programs initiated by the College in 2001 in response to the major categories of suggestions made by the Governors in 2000.

2002 Clinical Congress Program

The program for the 2002 Clinical Congress to be held October 6-10 in San Francisco, CA, was reviewed by the Board.

Joint CME Sponsorship Program

A progress report outlining initial results of the ACS Joint Continuing Medical Education (CME) Sponsorship Program was presented. Under the program, the ACS provides appropriate Category 1 credit hours for sur-

geons attending scientific programs sponsored by the College and surgical specialty organizations that qualify under the program. The inaugural joint sponsorship program was held in 2001 with the American Society of General Surgeons for their annual meeting in Toronto, ON. To date, five additional surgical organizations have submitted their applications for joint CME sponsorship with the College.

Committee on Young Surgeons

A report from this committee indicated that the 2002 Young Surgeon Representatives Program will be combined with the Chapter Leadership Program and held May 15-18, 2002. The program will include a combined reception and dinner for chapter officers, chapter administrators, and young surgeon representatives, and combined meetings of both groups. A workgroup for the young surgeon representatives will be held at the conclusion of the meeting.

Graduate Medical Education Committee (GMEC)

The Regents reviewed a report from this committee that indicated that the committee will sponsor the Surgeons as Educators Course, February 23 to March 1, 2002. The booklet, *Prerequisites for Graduate Surgical Education*, will be revised during the next several months to more effectively reflect Accreditation Council on Graduate Medical Education competencies. More than 30,000 copies have been distributed to date. The Student Mentoring Subcommittee of the GMEC held its second "Day at the American College of Surgeons," in New Orleans, LA, during the Clinical Congress, in cooperation with the New Orleans public school system and the Louisiana State University outreach program in science. Approximately 120 ethnic and minority mathematics and science students attended.

Candidate and Associate Society

The Regents were informed that the current enrollment of the Candidate and Associate So-

ciety of the American College of Surgeons is 6,374 members. The Council of Representatives now stands at 133. The society presented a symposium on resident work hours and the working environment on October 7 during the Clinical Congress.

Professional liability activities

The Regents considered an update on professional liability activities from the Committee on Patient Safety and Professional Liability. The committee is developing a new patient safety manual for distribution by the College. Several chapters have been completed and are being reviewed by members of the committee. The committee presented a postgraduate course, Professional Liability in a Changing Health Care Environment, and a panel program on Medical Errors: Improving Patient Safety—From Basic Science to Bedside, at the 2001 Clinical Congress.

Legislative/regulatory update

A review of College legislative and regulatory activities was presented to the Board. These activities included ACS efforts to influence legislation in the areas of managed care reform bills, medical records confidentiality, Medicare and physician payment issues, E/M documentation guidelines, anti-fraud and other enforcement issues, trauma emergency care and injury prevention, the Emergency Medical Treatment and Labor Act (EMTALA), and graduate medical education.

The College hosted a Medicare Reform Symposium in Washington, DC, this past summer for leaders in the surgical specialty societies. The event included presentations from the various stakeholder groups—insurers, beneficiaries, medical device manufacturers, and the pharmaceutical industry. The program was aimed at developing consensus recommendations from the various surgical specialties that the College can bring to policymakers on Capitol Hill and in the White House. In another activity, 19 chapters visited Washington, DC, this year as part

of the College's Chapter Visit Program.

The College completed its 2001 program of educational workshops on *Current Procedural Terminology* and ICD-9-CM coding for general surgeons. Workshops were held in San Francisco, CA, Chicago, IL, and Delavan, WI. A total of 146 surgeons attended the workshops. Sites and dates for 10 workshops proposed for 2002 were being finalized. The ACS continues its coding hotline to assist Fellows and their staffs with coding questions.

AMA House of Delegates meeting

The Regents received information on the July 17-21, 2001, AMA House of Delegates meeting. The ACS was represented by five delegates and a College representative to the AMA Young Physicians Section. The Surgical Caucus of the AMA met a day before the House of Delegates went into session. Thomas R. Russell, MD, FACS, ACS Executive Director, outlined the College's strategic planning activities at the Caucus meeting, and David L. Nahrwold, MD, FACS, a College Regent, presented a program on the surgical competence movement and the involvement of the College and the other surgical specialties.

Communications/informatics activities

An update on College communications and informatics activities was presented to the Board. By mid-September 2001, more than 2,000 online registration records had been processed for the Clinical Congress. The online program for the Congress was augmented this year with the addition of a searchable session finder. A virtual exhibit hall was added as a link to the Clinical Congress program information.

Development Program update

The Committee on Development reported that the College received cash contributions of \$764,400 during the 2001 calendar year. These contributions help to fund the ACS scholarship and research awards program.

Office of Evidence-Based Surgery

A status report indicated that this office was in the initial stage of building the infrastructure to support the various programs in the general area of outcomes research. As part of the College's strategic plan, the administrative and grant management of existing outcomes programs have been transferred to this office. In addition, this office is providing the administrative and grant management support for several outcomes projects in which the ACS is collaborating with outside organizations including the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality.

American College of Surgeons Oncology Group (ACOSOG)

The Regents were informed that the movement of the ACOSOG to the Duke University Medical Center went smoothly and the relationship of the program to the Duke Clinical Research Institute is positive. The Regents were updated on the status of the protocol development, the current status of patient accrual, and the recruitment of staff. The Board endorsed the College's continuation as the fundamental base and sponsor of ACOSOG.

Report of the Executive Director

Dr. Russell reported on meetings of the B/R Executive Committee and other matters. These items included presentation of the strategic plan to the Fellowship in the September *Bulletin*, at the meetings of the Board of Regents and the Board of Governors, and in the ACS Clinical Congress Resource Center. Other issues discussed included ACS staffing under the reorganization called for in the strategic plan, the proposed formation of the ACS 501(c)(6) organization, the ACS-proposed branding/marketing program, and approval of a three-year agreement with the College's health policy and advocacy consulting firm, Health Policy Alternatives, Inc. Dr. Russell has utilized a monthly electronic newsletter to inform Regents and ACS Officers of these developments.

Committee and council appointments

The Regents approved changes in membership for several College standing committees and specialty advisory councils.

Statements: Unconventional Acts of Civilian Terrorism and Disasters from Biological and Chemical Terrorism

The Regents reviewed a Statement on Unconventional Acts of Civilian Terrorism, prepared by the Chair of the B/G Committee on Blood-Borne Infection and Environmental Risk and approved by the Board of Governors at its October 10 adjourned meeting, and a Statement on Disasters from Biological and Chemical Terrorism—What Should the Individual Surgeon Do? prepared by the Chair of the Committee on Trauma. The statements were distributed as part of a special session at the Clinical Congress on Unconventional Civilian Disasters: What the Surgeon Should Know, presented by both chairs. The Regents recommended that the statements be disseminated to the Fellowship via the *Bulletin*, e-mail, and the College's Web site. The statements were posted on the ACS Web site on October 17, and all Fellows with e-mail addresses were notified of the link to the Web site in a special e-mail from Dr. Russell. The statements were also published in the November 2001 *Bulletin*, along with a special "From my perspective" column by Dr. Russell.



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You can also pay your dues online and search for contact information on other Fellows in the database.

Chapter news

by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news, please contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Southwest Missouri Chapter conducts fall meeting

The Southwest Missouri Chapter held its fall meeting on September 19 in Joplin. The meeting included the election of officers for 2002, and a presentation to the outgoing President, Allan Allphin, MD, FACS. New officers include Joseph Newman, MD, FACS, President; Thomas Pearson, MD, FACS, President-Elect; and John W. Buckner III, MD, FACS, Secretary-Treasurer. The educational portion of the program featured presentations on imaging, including breast imaging, stereotactic surgery, and positron emission tomography.

Connecticut Chapter meets

The Connecticut Chapter conducted its 2001 annual meeting November 6 in Waterbury. The day-long education program, which was attended by 150 Fellows, residents, and medical students, featured competitions for trauma, cancer, and general surgery papers, three "cine papers" (video presentations), and 22 poster presentations. Before the education program, various committees met, including the cancer liaison, trauma, and young surgeons committees. Thomas R. Russell, MD, FACS, the College's Executive Director, delivered the keynote address. In addition, Sherman Bull, MD, FACS, a Connecticut Chapter Past-President, related his experiences ascending Mt. Everest; Dr. Bull is the oldest man to summit, an achievement he completed with his son.

New Jersey Chapter observes 50th anniversary

The New Jersey Chapter conducted its 2001 annual meeting December 3 with more than 200 Fellows, Associate Fellows, Candidates, resi-

dents, and medical students in attendance. The day-long education program featured a paper competition for residents and medical students (see photo, p. 47), nine surgical specialty sessions, a luncheon, the Sheen Award Lecture, and the annual business meeting.

During the business meeting, R. Scott Jones, MD, FACS, the College's President, presented a 50th anniversary commemorative charter to officers of the New Jersey Chapter (see photo, p. 47). Also, during the luncheon, the 2001 Sheen Award was presented to James C. Thompson, MD, FACS, a Past-President of the College. His address was titled Endocrine Tumors of the Pancreas. Also during the business meeting, Art Ellenberger, Executive Director of the New Jersey Chapter, announced that Eric Munoz, MD, FACS, recently had been elected to a two-year term to the New Jersey Assembly. Mr. Ellenberger noted, too, that Dr. Munoz won his first election to statewide office by a significant majority (see photo, this page).



Dr. Munoz

New York Chapter

On October 6, 2001, the Board of Regents approved the formation of the New York Chapter. As a result of the Regents' action, the Upstate New York Chapter and the New York State Society of Surgeons will combine. The interim officers of the New York Chapter are John Nicholson, MD, FACS, President; Peter Max, MD, FACS, President-Elect; Saqib Chaudhry, MD, FACS, Secretary; and Peter D'Silva, MD, FACS, Treasurer. In addition, Heather Bennett, JD, will serve as Executive Director.



JUSTIN BAITER

New Jersey Chapter, left to right: Elizabeth Robinson; Gregory Albaugh, DO; Dr. Jones; Saraswati D. Dayal, MD*; and Arash Mohebat.



New Jersey Chapter: Displaying the 50th Anniversary New Jersey commemorative charter, left to right: H. Stephen Fletcher, MD, FACS, Treasurer; Paul LoVerme, MD, FACS, Vice-President; Dr. Jones; J. Thomas Davidson, MD, FACS, immediate Past-President; Robert W. Hobson II, MD, FACS, President; and Mr. Ellenberger.

Chapters continue support for the College's funds

During 2001, 19 chapters contributed a total of \$35,025 to the College's Endowment Funds. The chapters' commitment to the various funds support the College's pledge to surgical research and education. Chapters can contribute to several dif-

ferent funds, such as the Annual Fund, the Fellows Endowment Fund, or the Scholarship Fund. The chapters that contributed during 2001 include:

Life Members of the Fellows Leadership Society:[†] Arizona, Southern California, Louisiana, Maryland, Nebraska, Brooklyn-Long Island (NY), and Ohio.

Annual Members of the Fellows Leadership Society: Florida, South Florida, Georgia, Hong Kong, Illinois, Indiana, Metropolitan Chicago, Michigan, New Jersey, North Carolina, Metropolitan Philadelphia, North Texas, South Carolina, and Virginia.

Contributors: Maine, Alberta.

Chapter anniversaries

Month	Chapter	Years
January	Northern California	50
	Louisiana	50
February	Arizona	50
	Australia-New Zealand	17
	South Florida	48
	Iowa	34
	Italy	16
	Lebanon	39
	Montana-Wyoming	37
	Eastern Long-Island, NY	34
	Westchester, NY	50
	Peru	25
	South Korea	15
	Washington State	50

Leadership conference for officers and young surgeons

In 2002, two important education programs are being combined. These education programs

[†]The Fellows Leadership Society (FLS) is the distinguished donor organization of the College. Chapters that contribute at least \$1,000 annually are members. Chapters that have contributed \$25,000 are FLS Life Members.

*Denotes participant in the Candidate Group.

include the Young Surgeons Representatives Annual Meeting and the Chapter Leadership Conference. These programs will be held at the College's headquarters in Chicago, IL. A preliminary schedule for the combined event includes:

May 15: Half-day education program for chapter administrators and executive directors.

May 16: Full-day education program for chapter officers and chapter administrators; joint re-

ception and dinner for young surgeons, chapter officers, and chapter administrators.

May 17: Full-day education program for young surgeons, chapter officers, and chapter administrators, including plenary sessions and breakout workshops.

May 18: Half-day education program for young surgeons.

Next month in *JACS*

The March issue of the *Journal of the American College of Surgeons* will feature:

Original scientific articles:

- Identifying Patient Preoperative Risk
- Factors and Postoperative Events: VA NSQIP
- Factors Associated with Conversion to Laparotomy in Laparoscopic Appendectomy

Collective review:

- Overview of Bariatric Surgery

Ethics:

- Ethics and Philosophy Lecture

What's new

- In Trauma and Critical Care
- In Plastic and Maxillofacial Surgery

